

03024

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>10313 Parkman Rd</u>			
3. NAME OF DECEASED (Type or print) <u>William George Allen</u>				4. DATE OF DEATH <u>March 8 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-13</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Amer. Security Trust</u>		11. BIRTHPLACE (State or foreign country) <u>TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Will G. Allen</u>				14. MOTHER'S MAIDEN NAME <u>Lennie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Washington San. Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary Carcinoma of R Bronchus</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>March 8</u> , 19 <u>57</u> that I last saw the deceased alive on <u>March 7</u> , 19 <u>57</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Camille Ave Takoma Park Md</u>			
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>				DATE SIGNED <u>3-8-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BROOKVILLE METHODIST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BROOKVILLE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				ADDRESS <u>Silver Spring Md</u>		24a. REC'D BY REGISTRAR <u>John D. Bell</u>	
				DATE <u>3/11/57</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



03057

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				d. STREET ADDRESS <b>Easley 77X-3</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Thomas</b> Middle <b>Lee</b> Last <b>Atkinson</b>		4. DATE OF DEATH		Month <b>March</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 May 1928</b>		9. AGE (In years last birthday) <b>28</b> yrs.	IF UNDER 1 YEAR: Months <b>9</b> Days <b>19</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Canteen Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Dispensing</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William L. Atkinson</b>				14. MOTHER'S MAIDEN NAME <b>Annie Carnes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <b>No</b>		16. SOCIAL SECURITY NO. <b>247-36-5220</b>		17. INFORMANT <b>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>411X</b> DUE TO <b>Aortic Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>5 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>17 March</b> , 19 <b>57</b> , to <b>19 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>19 March</b> , 19 <b>57</b> , and that death occurred at <b>11.15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center, National Institutes of Health, Bethesda, Md., Maryland</b> DATE SIGNED <b>3/20/57</b>							
ACTUAL SIGNATURE <b>Edward G. Biglieri</b> PHYSICIAN'S NAME (Type) <b>Edward G. Biglieri, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipment</b>		22b. DATE THEREOF <b>3/19/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Easley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easley, South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>9-21-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 26 1957

RECEIVED



03058

CERTIFICATE OF DEATH

03028

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>72 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena 02X22</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>no street address</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Della</b> Middle <b>Virginia</b> Last <b>Bailey</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 23, 1885</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.		IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Richard Roberts</b>				14. MOTHER'S MAIDEN NAME <b>Laura Mathaney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>493X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic carcinoma of the breast</b> DUE TO <b>metastatic carcinoma of the breast</b> (c) <b>metastatic carcinoma of the breast</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>asthma</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>0</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>0</b>	
20f. (City or town) <b>0</b>				20g. (County) <b>0</b>		20h. (State) <b>0</b>	
21. I certify that I attended the deceased from <b>January 14, 1957</b> , to <b>March 27, 1957</b> , that I last saw the deceased alive on <b>March 27, 1957</b> , and that death occurred at <b>3:25 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/28/57</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Thomas Waldmann</b> M.D.				PHYSICIAN'S NAME (Type) <b>Thomas Waldmann, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 30/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. L. Sington</b>				24a. REC'D BY REGISTRAR <b>APR 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED  
APR 3 1957  
BUREAU V. S.

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		White		January 1, 1912		New York, N.Y.		January 15, 1957		New York, N.Y.		Heart Disease		Natural		J. Smith, M.D.		A. B. C.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

03059

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Rockville</b> c. LENGTH OF STAY IN 1b <b>x2 Rural-Rockville</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Swains Lock Road</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Swains Lock Road</b> d. STREET ADDRESS <b>Swains Lock Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN WILLIAM BAKER</b> First Middle Last				4. DATE OF DEATH <b>March 22, 1957</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 25, 1884</b>	
9. AGE (in years last birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret-Ecucuator</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William Baker</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Nellie Baker-Item# 2</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>3/23/57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Gabriels Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Potomac Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumpfrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>3/26/57</b>		24b. REGISTRAR'S SIGNATURE <b>Laurell Kragtorp</b> <b>Deel E.C.</b>	

MAR 27 1957

BUREAU V. B.

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11,503 Broadview Road</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Callie</b> Middle <b>Calaway</b> Last <b>Barker</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 7, 1887/1888</b>	
9. AGE (In years last birthday) <b>69 yrs.</b>		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Track Foreman (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>C.&amp;O. Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>James E. Barker</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Barker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>719-07-4822</b>			
17. INFORMANT <b>Mr. Robert G. Barker, 11,503 Broadview Rd.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Silver Spring, Md.</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>18 March 19 57</b> , to <b>18 March 19 57</b> , that I last saw the deceased alive on <b>18 March 19 57</b> , and that death occurred at <b>4:30 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11602 Georgia Ave Silver Spring</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Morris Perry</b>				M.D. <b>11602 Georgia Ave</b>			
PHYSICIAN'S NAME (Type) <b>Morris Perry</b>				<b>Silver Spring</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BARKER CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ASHFORD, BOONE COUNTY, W. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>3/20/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03031

03061

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Lewisdale</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. Monrovia.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Altie</b> Middle <b>E.</b> Last <b>Beall</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30. 1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Lewisdale, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John M. King</b>		14. MOTHER'S MAIDEN NAME <b>Mary B. King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs T. Deets Day, Monrovia, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO <b>Generalized Arteriosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs ?</b> <b>15 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1935</b> , 19____, to 19____, that I last saw the deceased alive on <b>March 14</b> , 19 <b>57</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Druid Theatre Building, 3/15/57</b> <b>Damascus, Maryland.</b>			
ACTUAL SIGNATURE <b>M. McKendree Boyer, M.D.</b>		M.D. <b>Druid Theatre Building, 3/15/57</b> <b>Damascus, Maryland.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 17, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas L. Moleworth</b>		ADDRESS <b>Damascus, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>March 16</b>		24b. REGISTRAR'S SIGNATURE <b>Wella W. Burdette</b>	

RECEIVED  
MAR 19 1957  
BUREAU V. 3

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE TO		CERTIFICATE OF DEATH	
NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF BURIAL		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
NAME OF WITNESSES		NAME OF REGISTRAR	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
OFFICIAL SEAL		OFFICIAL SEAL	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
03062 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03032

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>14609 Harlingwa</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>Berry</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1956</u>			
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John W. Berry</u>				14. MOTHER'S MAIDEN NAME <u>Janet M. Holland</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Father</u> Address <u>—</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia both lower lobes &amp; upper right</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral edema. Sarg. Thymus 34.2 gms.</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>							
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron</u>			
22d. LOCATION (City, town, or county) (State) <u>Winchester, Va.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda Md.</u>		24a. REC'D BY REGISTRAR <u>3-5-57</u>			
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>									

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03063

CERTIFICATE OF DEATH

03033

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>5 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47x-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		d. STREET ADDRESS <b>3919 Harrison St. NW</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sophia</b> First <b>Elizabeth</b> Middle <b>Brandon</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1871</b>
9. AGE (In years birthday) yrs. <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Claude Williams</b>		14. MOTHER'S MAIDEN NAME <b>Ann Myrick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>J. Ralph</b>		Address <b>- 1303 N. Ode Street - Arlington</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalised and</b> DUE TO (c) <b>Severe Secondary anemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Metastatic carcinoma from breast carcinoma</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1952</b> to <b>March 7, 1957</b> , that I last saw the deceased alive on <b>March 7, 1957</b> , and that death occurred at <b>11:40 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3921 Ingomar St. N.W. Wash 15 D.C.</b> DATE SIGNED <b>3-8-57</b>			
ACTUAL SIGNATURE <b>Stewart Clapp</b>		M.D. <b>3921 Ingomar St. N.W. Wash 15 D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>3/12/57</b>	<b>Fort Lincoln Cem.</b>	<b>Bladensburg Rd Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chung Chae Funeral Home</b>		ADDRESS <b>5103 The Ave NW</b>	24a. REC'D BY REGISTRAR <b>3-11-57</b>
		24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - FACILITY ONE 1B

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 10/10/1928		PLACE OF BIRTH MOBILE, ALABAMA	
MIDDLE NAME EARL		SEX MALE		RACE WHITE	
MARRIAGE MARRIED		DATE OF MARRIAGE 11/10/1950		PLACE OF MARRIAGE MEMPHIS, TENNESSEE	
OCCUPATION ATTORNEY		EDUCATION HIGH SCHOOL		RELIGION METHODIST	
DATE OF DEATH 4/4/68		PLACE OF DEATH MEMPHIS, TENNESSEE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF MINISTER (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF DEATH REGISTRAR (None)		SIGNATURE OF COUNTY CLERK (None)		SIGNATURE OF STATE CLERK (None)	

BUREAU V. S.

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Item 1 Film G213 4-11-57 et

03064

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: <i>1201 Dunton Street</i>	
COUNTY <i>Maryland</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Mont</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>571 University Blvd</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED: (First) <i>Frank</i> (Middle) <i>B</i> (Last) <i>Bright</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>3 28 1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>WIDOWED</i>	8. DATE OF BIRTH: <i>July 9</i>
9. AGE last birthday <i>85?</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired Engineer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Raymond</i>	
11. BIRTHPLACE (State or foreign country): <i>Washington D.C</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Jacob Bright</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>0</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Harold Stuyvesant, 1521 Dale Drive, Suit Rm.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Myocardial Infarction</i>			<i>6 hrs</i>
ANTECEDENT CAUSE (S) <i>Arteriosclerotic Heart Disease</i>			<i>approx 20 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug</i> , 1955, to <i>March</i> , 1957, that I last saw the deceased alive on <i>March 28, 1957</i> , and that death occurred at <i>1:40 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Ralph P. Patten</i>		DATE SIGNED <i>March 28, 57</i>	
M. D. <i>8641-Colesville Road</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>3-30-57</i>	NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	LOCATION (City, town, or county) (State) <i>Switland Md</i>
DATE REC'D BY LOCAL REGISTRAR <i>3/30/57</i>	REGISTRAR'S SIGNATURE <i>Frances Patten</i>	24. FUNERAL DIRECTOR <i>Neal Frances Home</i>	ADDRESS <i>4812 So. Ave. Md</i>

RECEIVED

APR 4 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03035

03065

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>ENGLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sumner</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>London</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5707 Rockmere Drive</b>		d. STREET ADDRESS <b>90X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>ELAINE</b> Middle <b>Matilda</b> Last <b>BROOKE</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1884</b>
9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>22</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>London, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>England</b>	
13. FATHER'S NAME <b>George August Werner vonPirch</b>		14. MOTHER'S MAIDEN NAME <b>Susan Hill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Elaine M. vonTempelhoff</b>		Address <b>Item #1.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive arteriosclerotic Heart Disease</b> DUE TO (c) <b>several years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 11<sup>th</sup></b> , 19 <b>57</b> , to <b>March 20<sup>th</sup></b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 16<sup>th</sup></b> , 19 <b>57</b> , and that death occurred at <b>9:30 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. K. DUSCHAK</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>2025 Eye St. N.W., Wash. D.C. 3/21/57</b>	
PHYSICIAN'S NAME (Type) <b>G. K. DUSCHAK</b>		<b>2025 Eye St., N.W., Washington, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3/23/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>3-28-57</b>		24b. REGISTRAR'S SIGNATURE <b>Tessie M. Thompson</b>	

**BUREAU Y. S.**

MAR 26 1957

RECEIVED

03066

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH <u>3-14-57</u>				5. DATE OF DEATH <u>3-14-57</u>			
6. NAME OF DECEASED (Type or print) <u>FRANK FREDRICK BROWER</u>				7. NAME OF DECEASED (Type or print) <u>FRANK FREDRICK BROWER</u>			
8. SEX <u>Male</u>		9. COLOR OR RACE <u>White</u>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		11. DATE OF BIRTH <u>1889-Jan 30</u>	
12. AGE (In years last birthday) <u>68</u> yrs.		13. IF UNDER 1 YEAR Months Days Hours Min.		14. IF UNDER 24 HRS. Months Days Hours Min.		15. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>				16b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>			
17. BIRTHPLACE (State or foreign country) <u>Penn. Allegheny Co</u>				18. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
19. FATHER'S NAME <u>FRANK FREDRICK BROWER</u>				20. MOTHER'S MAIDEN NAME <u>Halfhill, J.</u>			
21. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				22. SOCIAL SECURITY NO. <u>1111111111</u>			
23. ADDRESS <u>1111111111</u>				24. ADDRESS <u>1111111111</u>			
25. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Head of Pancreas</u> DUE TO (b) <u>157x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>157x</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Arteriosclerosis, Generalized</u>							
26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
27. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
28. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		29. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		30. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		31. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 Mar</u> , 1957, to <u>13 Mar</u> , 1957, that I last saw the deceased alive on <u>12 Mar</u> , 1957, and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. E. ASH</u>				DATE SIGNED <u>14 Mar 57</u>			
PHYSICIAN'S NAME (Type) <u>J. E. ASH</u>				M.D. <u>Suburban Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				ADDRESS <u>4812 La Crosse Ave, Wash DC</u>			
24a. REC'D BY REGISTRAR <u>18 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1957

BUREAU V. 3

MAR 18 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03037

03067

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Incl</b>		d. STREET ADDRESS <b>13x22</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Nolan</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garage Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Amanda N. Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-36-9960</b>	
17. INFORMANT <b>Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ruptured infarct of left ventricle</b> (c) <b>coronary thrombosis, left main coronary</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b> <b>immed.</b> <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 1</b> , 19 <b>56</b> , to <b>March 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 10</b> , 19 <b>57</b> , and that death occurred at <b>3:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>C. S. Whitaker, M. D.</b>		<b>Clarksville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-14-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		22d. LOCATION (City, town, or county) (State) <b>Glenelg, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Bertrude Lawley</b>			

RECEIVED  
MAR 13 1957

## CERTIFICATE OF DEATH

Reg. Dist. No.

03038 216

03068

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>43 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47x-3</b>			
d. STREET ADDRESS <b>1401 Ridge Place, S.E., Anacostia</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Clinton</b>		First <b>Henderson</b>		Last <b>Bryant</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 9, 1890</b>		9. AGE (In years last birthday) <b>67</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Street Car Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transit Company</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Bryant</b>				14. MOTHER'S MAIDEN NAME <b>Lula Harrison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-5078</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the esophagus</b> <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 radiation pneumonitis.</b> DUE TO (c) <b>pulmonary metastasis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 24, 1957</b> , to <b>March 8, 1957</b> , that I last saw the deceased alive on <b>March 8, 1957</b> , and that death occurred at <b>6:07 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/9/57</b> ACTUAL SIGNATURE <b>David G. Nathan</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>DAVID G. NATHAN, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-12-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee - Wash D. C.</b>				24. REC'D BY REGISTRAR <b>MAR 13 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 13 1957

BUREAU V. 2

3-15-57  
J. W. F. Kinn - Work L. G.

The Clinical Center  
National Institute of Health  
Bethesda, Md., Maryland

LEWIS G. HATHAWAY, M.D.

March 8 1957

January 25 1957 March 8 1957

252-10-1076 The Clinical Center, Bethesda, Md., Maryland

The Medical Record  
Miss Barbara

Street Car Operator  
Traveling Company  
Virginia

Male  
White  
January 2, 1950

Alston  
Henderson Hyatt  
March 8

The Clinical Center, Bethesda, Md., 1100 Ridge Place, S.W., Washington

Bethesda, Md., Maryland  
13 days  
Washington

Marion  
D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03069

## CERTIFICATE OF DEATH

03039

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Partnership Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Clara Elizabeth Burdette</b>				4. DATE OF DEATH <b>March 29 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2 1866</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Jane Thompson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Myrtle Hough Dickerson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Jaundice</b> DUE TO (c) <b>Carinomatous</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 weeks</b> <b>2 months</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>20 Sept. 19 48</b> , to <b>March 29 19 57</b> , that I last saw the deceased alive on <b>March 27 19 57</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John G. Lawrence</b>				ADDRESS (Street, city or town, state) <b>P.O. Bayol, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>JOHN G. LAWRETT</b>				DATE SIGNED <b>3/29/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 31 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Boys</b>		22d. LOCATION (City, town, or county) <b>Boys Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>				ADDRESS <b>Laytonville, Md.</b>		24a. REC'D BY REGISTRAR <b>4/2/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles W. Elgin</b>			



CERTIFICATE OF DEATH

12069

Name of Deceased		John Thompson	
Sex		Male	
Age		45	
Date of Birth		March 15, 1890	
Place of Birth		Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Date of Death		April 10, 1935	
Place of Death		Baltimore, Maryland	
Occupation		None	
Signature of Physician		John Thompson	
Signature of Registrar		Jane Thompson	
Signature of Informant		John Thompson	
Address of Informant		Baltimore, Maryland	
Date of Report		April 10, 1935	
Registrar's Office		Baltimore, Maryland	
County		Baltimore	
State		Maryland	
U.S.A.			

BUREAU V. S.

APR 3 1935

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 File # 0212 3-21-57 et

03025

## CERTIFICATE OF DEATH

Reg. Dist. No.

03040  
223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>7423 Aspen St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Colin</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-70</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>India</u>	
13. FATHER'S NAME <u>Ardisbald Campbell</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Washington Sanitarium &amp; Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, Hypertension</u> DUE TO (c) <u>Senility</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac decompensation</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Mar</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 11</u> , 19 <u>57</u> , and that death occurred at <u>2:25 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Raymond O. West</u> M.D. <u>7600 Carroll Ave Takoma Park</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>3/13/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Michael D. H.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03070

## CERTIFICATE OF DEATH

Reg. Dist. No.

03044  
2

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>12 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>805 KING STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>DANIEL JOHN CARR</b>				4. DATE OF DEATH <b>MARCH 2</b> 19 <b>57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 24, 1886</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PEOPLES DRUG STORES ROCKVILLE, MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM HENRY CARR</b>				14. MOTHER'S MAIDEN NAME <b>EMMA KLIENDIENST</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. MARY B. CARR, same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PHARYNX</b> <b>148X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1948</b> , to <b>Mar. 1957</b> , that I last saw the deceased alive on <b>2 Mar. 1957</b> , and that death occurred at <b>10:30 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. B. Snow</b>				ADDRESS (Street, city or town, state) <b>9013 Flower Ave. SILVER SPRING, MD.</b>			
PHYSICIAN'S NAME (Type) <b>L. B. SNOW</b>				DATE SIGNED <b>3/3/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 6, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ROCKVILLE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>3/5/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



03071

## CERTIFICATE OF DEATH

Reg. Dist. No.

2/6

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1 210 GRANVILLE DRIVE</b>			
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>CHRISTENSEN</b> Middle <b>CHRISTENSEN</b> Last				4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 15, 1887</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager (retired) Supply</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State Brand Dept. Creameries, Inc.</b>			
11. BIRTHPLACE (State or foreign country) <b>DENMARK</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JENS CHRISTENSEN</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTIANA LARSEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Oda J. Christensen, 210 Granville Drive</b>				Address <b>Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia, Lymphocytic</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6-8 mo</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1955</b> to <b>4 March, 1957</b> that I last saw the deceased alive on <b>3 March, 1957</b> , and that death occurred at <b>11:10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.				ADDRESS (Street, city or town, state) <b>906 Calisville Rd</b> DATE SIGNED <b>3/4/57</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>				<b>Silver Spring, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>8-6-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bernie M. Hornum</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

MAR 8 1957

BUREAU V. S.

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. MANNER OF DEATH	
9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR	
11. DATE OF DEATH	
12. PLACE OF DEATH	
13. SIGNATURE OF WITNESS	
14. SIGNATURE OF DECEASED	
15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF BURIAL OFFICIAL	
17. SIGNATURE OF FUNERAL HOME	
18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF INTERVIEWER	
20. SIGNATURE OF SUPERVISOR	
21. SIGNATURE OF ASSISTANT SUPERVISOR	
22. SIGNATURE OF CLERK	
23. SIGNATURE OF RECEPTIONIST	
24. SIGNATURE OF MAIL ROOM	
25. SIGNATURE OF TELEPHONE ROOM	
26. SIGNATURE OF JANITOR	
27. SIGNATURE OF NIGHT SUPERVISOR	
28. SIGNATURE OF NIGHT ASSISTANT	
29. SIGNATURE OF NIGHT CLERK	
30. SIGNATURE OF NIGHT RECEPTIONIST	
31. SIGNATURE OF NIGHT MAIL ROOM	
32. SIGNATURE OF NIGHT TELEPHONE ROOM	
33. SIGNATURE OF NIGHT JANITOR	
34. SIGNATURE OF NIGHT SUPERVISOR	
35. SIGNATURE OF NIGHT ASSISTANT	
36. SIGNATURE OF NIGHT CLERK	
37. SIGNATURE OF NIGHT RECEPTIONIST	
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40. SIGNATURE OF NIGHT JANITOR	
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42. SIGNATURE OF NIGHT ASSISTANT	
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44. SIGNATURE OF NIGHT RECEPTIONIST	
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47. SIGNATURE OF NIGHT JANITOR	
48. SIGNATURE OF NIGHT SUPERVISOR	
49. SIGNATURE OF NIGHT ASSISTANT	
50. SIGNATURE OF NIGHT CLERK	
51. SIGNATURE OF NIGHT RECEPTIONIST	
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54. SIGNATURE OF NIGHT JANITOR	
55. SIGNATURE OF NIGHT SUPERVISOR	
56. SIGNATURE OF NIGHT ASSISTANT	
57. SIGNATURE OF NIGHT CLERK	
58. SIGNATURE OF NIGHT RECEPTIONIST	
59. SIGNATURE OF NIGHT MAIL ROOM	
60. SIGNATURE OF NIGHT TELEPHONE ROOM	
61. SIGNATURE OF NIGHT JANITOR	
62. SIGNATURE OF NIGHT SUPERVISOR	
63. SIGNATURE OF NIGHT ASSISTANT	
64. SIGNATURE OF NIGHT CLERK	
65. SIGNATURE OF NIGHT RECEPTIONIST	
66. SIGNATURE OF NIGHT MAIL ROOM	
67. SIGNATURE OF NIGHT TELEPHONE ROOM	
68. SIGNATURE OF NIGHT JANITOR	
69. SIGNATURE OF NIGHT SUPERVISOR	
70. SIGNATURE OF NIGHT ASSISTANT	
71. SIGNATURE OF NIGHT CLERK	
72. SIGNATURE OF NIGHT RECEPTIONIST	
73. SIGNATURE OF NIGHT MAIL ROOM	
74. SIGNATURE OF NIGHT TELEPHONE ROOM	
75. SIGNATURE OF NIGHT JANITOR	
76. SIGNATURE OF NIGHT SUPERVISOR	
77. SIGNATURE OF NIGHT ASSISTANT	
78. SIGNATURE OF NIGHT CLERK	
79. SIGNATURE OF NIGHT RECEPTIONIST	
80. SIGNATURE OF NIGHT MAIL ROOM	
81. SIGNATURE OF NIGHT TELEPHONE ROOM	
82. SIGNATURE OF NIGHT JANITOR	
83. SIGNATURE OF NIGHT SUPERVISOR	
84. SIGNATURE OF NIGHT ASSISTANT	
85. SIGNATURE OF NIGHT CLERK	
86. SIGNATURE OF NIGHT RECEPTIONIST	
87. SIGNATURE OF NIGHT MAIL ROOM	
88. SIGNATURE OF NIGHT TELEPHONE ROOM	
89. SIGNATURE OF NIGHT JANITOR	
90. SIGNATURE OF NIGHT SUPERVISOR	
91. SIGNATURE OF NIGHT ASSISTANT	
92. SIGNATURE OF NIGHT CLERK	
93. SIGNATURE OF NIGHT RECEPTIONIST	
94. SIGNATURE OF NIGHT MAIL ROOM	
95. SIGNATURE OF NIGHT TELEPHONE ROOM	
96. SIGNATURE OF NIGHT JANITOR	
97. SIGNATURE OF NIGHT SUPERVISOR	
98. SIGNATURE OF NIGHT ASSISTANT	
99. SIGNATURE OF NIGHT CLERK	
100. SIGNATURE OF NIGHT RECEPTIONIST	

03072

## CERTIFICATE OF DEATH

03043

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>West Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>258 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				d. STREET ADDRESS <b>None- General Delivery</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Otho</b>		First <b>Otho</b> Middle <b>Olders</b> Last <b>Colvin</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 January 1883</b>	
9. AGE (In years lost birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry Colvin</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Ross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Not available</b>			
17. INFORMANT <b>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150x</b> <b>Pulmonary insufficiency 2nd to radiation</b> DUE TO <b>perforated</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinophagus, post irradiation</b> DUE TO (c) <b>Acute cadaveric A and P</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b> <b>18 mos.</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11 July</b> , 19 <b>56</b> , to <b>26 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>26 March</b> , 19 <b>57</b> , and that death occurred at <b>6.30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/26/57</b>							
ACTUAL SIGNATURE <b>Peter D. Olch, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Peter D. Olch, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<b>Burial-Transit 3-27-57</b>				<b>Greenwood Memorial Cem.</b>		<b>Riley County, W. Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 3-28-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 1 1957

BUREAU V. S.

03073

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> 47X-3		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>			d. STREET ADDRESS <u>511 4th Street, S.E.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Belisario (nmn) CONTRERAS</u>			4. DATE OF DEATH Month Day Year <u>March 6 19 56</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 Oct. 1887</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Spain</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Belisario Contreras</u>			14. MOTHER'S MAIDEN NAME <u>Berardi Ramos</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 1-20-09 to 9-1-40</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>(Official Navy Records)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Glomerulonephritis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dysenteritis of colon</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>27 Feb.</u> , 19 <u>57</u> , to <u>6 March</u> , 19 <u>57</u> , that I lost the deceased alive on <u>6 March</u> , 19 <u>57</u> , and that death occurred at <u>01:00 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W.C.E. Pfischner</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 6 Mar. 57</u>			
PHYSICIAN'S NAME (Type) <u>W.C.E. Pfischner, LCDR, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Funeral Home</u>		ADDRESS <u>Wash. D. C. 517 11th St., S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>3-6-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>May E. Parrelly</u>	

TO TO BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO. 100

MARYLAND

1957

Washington

State

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03074

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Md.</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS <b>1343 Montague Street, N. W.</b>			
3. NAME OF DECEASED (Type or print)		First <b>Hermene</b> Middle <b>Leon</b> Last <b>Cook</b>		4. DATE OF DEATH		Month <b>March</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 24, 1922</b>		9. AGE (In years lost birthday) <b>34</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John T. Cook</b>				14. MOTHER'S MAIDEN NAME <b>Albina Boulay</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Korean</b>		16. SOCIAL SECURITY NO. <b>005-16-4752</b>		17. INFORMANT <b>The Medical Record</b> address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT MELANOMA WITH 190x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTASES TO LIVER AND ADRENALS</b> DUE TO (c) <b>13 MOS</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RETROPERITONEAL HEMORRHAGE</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 9, 1957</b> , to <b>March 3, 1957</b> , that I last saw the deceased alive on <b>March 3, 1957</b> <del>XXXXXX</del> and that death occurred at <b>2:00P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/4/57</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Samuel Charache</b> M.D.		PHYSICIAN'S NAME (Type) <b>Samuel Charache, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BUR* Transil</b>		22b. DATE THEREOF <b>3/4/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Portland, Maine</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>3-5-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Minister of Columbia

Montgomery

Washington

35 days

Bethesda, Md., Md.

1313 Montague Street, N.W.

The Clinton Center, Bethesda, Md., Md.

Cook

Leon

Harrison

September 24, 1952

White

U. S. A.

White

Automobile

Californian

Alma Boyer

John T. Cook

The Medical Record

The Clinton Center, Bethesda, Md., Maryland

001-16-1722

Korean

Yes

BUREAU V. S.

February 2, 1953

March 3, 1953

MAR 7 1957

The Clinton Center

National Institute of Health

Bethesda, Md., Maryland

RECEIVED

## CERTIFICATE OF DEATH

03026

Reg. Dist. No. 120

03046

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>West Hyattsville</u> 1615-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>2720 Kirkwood Place</u>	
3. NAME OF DECEASED (Type or print) <u>Infant Boy Craver</u>		4. DATE OF DEATH <u>March 26</u> 19 <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1957</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fred McGill Craver</u>		14. MOTHER'S MAIDEN NAME <u>Joan Marie Eaton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ateletasis.</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/25</u> , 19 <u>57</u> , to <u>3/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>57</u> , and that death occurred at <u>1:00</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>925 Pershing Drive</u> DATE SIGNED <u>3/26/57</u> ACTUAL SIGNATURE <u>Raymond Chinn</u> M.D. <u>Silver Spring Md.</u> PHYSICIAN'S NAME (Type) <u>Raymond Chinn, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-28-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. &amp; Hospital Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Harchuk</u> ADDRESS <u>Washington Sanitarium &amp; Hosp.</u>		24a. REC'D BY REGISTRAR DATE <u>3/30/57</u>	
24b. REGISTRAR'S SIGNATURE <u>John R. Rode</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



03075

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY <b>Sullivan</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>		c. LENGTH OF STAY IN 1b <b>45 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsport 79x-3</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>1812 B Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>William</b> Last <b>Crawford</b>			4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 1, 1936</b>		9. AGE (In years last birthday) yrs. <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Ace Crawford</b>			14. MOTHER'S MAIDEN NAME <b>Mabel Gaylion</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> <b>754.4</b> DUE TO <b>Post operative Closure of I &amp; S.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Hofstein's Disease (Malformation) of the Heart &amp; IASD</b> (c) <b>Congenital</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year <b>19 57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Kingsport, Tennessee</b>	(County) (State)
21. I certify that I attended the deceased from <b>January 27, 1957</b> , to <b>March 13, 1957</b> , that I last saw the deceased alive on <b>March 13, 1957</b> , and that death occurred at <b>2:20 A.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Edward H. Sharp</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>		DATE SIGNED <b>3/13/57</b>	
PHYSICIAN'S NAME (Type) <b>Edward H. Sharp, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>3/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>East Lawn Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Kingsport, Tennessee</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, 7557 Wisc. Ave. Beth. Md.</b>			24a. REC'D BY REGISTRAR <b>3-14-57</b> 24b. REGISTRAR'S SIGNATURE <b>Brian M. Thompson</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1957

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

RESIDENCE

AGE

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

RESIDENCE

AGE

DATE OF BIRTH

PLACE OF BIRTH

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

RESIDENCE

AGE

BUREAU A. B.

MAR 18 1957

RECEIVED

03076

## CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH o. COUNTY <u>Montg</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Rural</u>				c. LENGTH OF STAY IN 1b <u>69 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Gaithersburg Rural No3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wallace Montgomery Crown</u>				4. DATE OF DEATH Month Day Year <u>Mar 9 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18-1888</u>	9. AGE (In years last birthday) <u>69 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>0 21</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Montg. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>James M. Crown</u>				14. MOTHER'S MAIDEN NAME <u>Sarah V Case</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Forest F. Crown, Gaithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatal Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Supratentorial</u> DUE TO (c) <u>Epileptiform attacks</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>10 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>March 9, 1957</u> , that I last saw the deceased alive on <u>Feb 15, 1957</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGN <u>26 N. Summit Ave. Gaithersburg Md.</u>							
ACTUAL SIGNATURE <u>W. R. Linthicum</u> M.D.				PHYSICIAN'S NAME (Type) <u>Wm A. Linthicum</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest G. Gartner</u>				ADDRESS <u>Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-11-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Abner L. Coe</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 10

BUREAU V. S.

MAR 15 1957

RECEIVED

03077

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>112 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>Rosie</b> Middle <b>Lee</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 25, 1914</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Waitress Work</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Tom Nicks</b>				14. MOTHER'S MAIDEN NAME <b>Ida Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-30-8907</b>			
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>171X</b> DUE TO <b>Metastatic carcinoma liver spleen lung and bilateral hydrocephalus. Original site - Cervix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 19, 1956</b> to <b>March 11, 1957</b> , that I last saw the deceased alive on <b>March 11, 1957</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/11/57</b> NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-15-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEM</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ford Funeral Home</b>				24. RECEIVED BY REGISTRAR <b>RECEIVED</b>			
25. REGISTRAR'S SIGNATURE <b>Debbie Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

42071

Residence of the deceased

Place of death

The Clinical Center, Bethesda, Md.

Age

Sex

Marital status

Occupation

Education

Religion

Cause of death

Manner of death

Signature of physician

Signature of medical examiner

Date

Place of death

Signature of registrar

Signature of informant

Signature of funeral director

BUREAU V. 5

MAR 18 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03027

## CERTIFICATE OF DEATH

Reg. Dist. No.

03050

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>11 hrs.</u>				d. STREET ADDRESS <u>8504 Flower Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John PAUL DECKER</u>				4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/14/194</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JHU / OPL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>E/za Decker</u>				14. MOTHER'S MAIDEN NAME <u>Bird Hart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW #1</u>		16. SOCIAL SECURITY NO. <u>578-24-9474</u>		17. INFORMANT <u>Patient's chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bacterial Pneumonia (Rt Mid-Lobe)</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Hypertrophy of Heart with marked Coronary Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/29</u> , 19 <u>52</u> , to <u>3/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>57</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dean H. Harding</u>				ADDRESS (Street, city or town, state) <u>113 Carroll St NW Wash</u>			
PHYSICIAN'S NAME (Type) <u>DEAN H. HARDING</u>				DATE SIGNED <u>3/5/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Humphrey</u>				ADDRESS <u>8434 Georgia Ave Maryland</u>		24a. REC'D BY REGISTRAR <u>3/8/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIED		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PREVIOUS ILLNESS		MEDICAL HISTORY	
SURVIVAL		REMARKS	
SIGNATURE		DATE	
WITNESSES		DOCTOR	
FAMILY		CLERGY	
FRIENDS		OTHER	
BUREAU V. R.		MAR 12 1957	
RECEIVED		MAR 12 1957	

03028

## CERTIFICATE OF DEATH

Reg. Dist. No.

030513

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>		d. STREET ADDRESS <u>2029 Conn. Ave., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Malvern</u> Last <u>Denit</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Denit</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Mac Pherson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>578-24-8464</u>	
17. INFORMANT <u>Washington Sanitarium &amp; Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> 260X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/9/53</u> , 19 <u>53</u> , to <u>3/7/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/7/57</u> , 19 <u>57</u> , and that death occurred at <u>2:23 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen Lee</u>		ADDRESS (Street, city or town, state) <u>2000 P St NW #415</u>	
PHYSICIAN'S NAME (Type) <u>ALLEN LEE</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga An Rd.</u>	
24a. REC'D BY REGISTRAR <u>3/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>Allen Lee</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAKELAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MAR 13 1951

BUREAU

# RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03078

## CERTIFICATE OF DEATH

030524

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>6 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12,814 HOLDRIDGE ROAD</b>				d. STREET ADDRESS <b>12,814 HOLDRIDGE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EUGENE (nmi) DICKENS</b>				4. DATE OF DEATH Month Day Year <b>MARCH 10 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 31, 1881</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ENGINEER AT SOLDIERS' HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>VIRGINIA</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>EDWARD S. DICKENS</b>				14. MOTHER'S MAIDEN NAME <b>MARY OWENS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-34-9751</b>		17. INFORMANT Address <b>MRS. EDITH ELLEN DICKENS, Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 years</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>50</b> , to <b>March 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 6</b> , 19 <b>57</b> , and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Samuel M Bageant M.D. 5600 N.H. Ave Wash., D.C.</b>							
ACTUAL SIGNATURE <b>SAMUEL M BAGEANT</b>		PHYSICIAN'S NAME (Type) <b>SAMUEL M BAGEANT</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE'S CO., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Rumpfrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>3/13/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1992

BUREAU V. S.

19 MAR 1957

RECEIVED

03079

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2417 East West Hwy.</u>			
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>DOHERTY</u> Last <u>DOHERTY</u>				4. DATE OF DEATH Month <u>3</u> - Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Naturalized</u>							
13. FATHER'S NAME <u>MARTIN Fitzpatrick</u>				14. MOTHER'S MAIDEN NAME <u>Bridgett DILLON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (daughter) <u>Marion McCarthy</u> Address <u>824 Summer Set Place Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis &amp; Encephalomalacia, right</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis &amp; Arterioventricular H.D.</u> DUE TO (c) <u>Generalized arteriosclerosis.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 7</u> 19 <u>57</u> , to <u>March 20</u> 19 <u>57</u> , that I last saw the deceased alive on <u>March 20</u> 19 <u>57</u> , and that death occurred at <u>1:57 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4325 - 49th St. N.W.; Wash. D.C.</u>				DATE SIGNED <u>3/20/57</u>			
ACTUAL SIGNATURE <u>Clifton R. Gruver</u>				M.D. <u>4325 - 49th St. N.W.; Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Clifton R. Gruver, M.D.</u>				4325 - 49th St. N. W., Wash. D. C. 3/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>3/22/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Denis</u>		22d. LOCATION (City, town, or county) (State) <u>Delaware County Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 3-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bernie H. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1957

Form No. 10

July 18, 1957

83

Bridgeport

Bridgeport

None

No

BUREAU V. B.

MAR 26 1957

RECEIVED

Robert A. Humphrey-1557 W. Ave. Bethesda, Md.

St. Louis 3/23/1957

Clinton L. Grover, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03054

03080

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>47X-3</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>349 Da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 7, D. C.</u> ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor San.</u>				d. STREET ADDRESS <u>1323-30th ST. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Sullivan</u> Last <u>Dolan</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-7-1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Georgetown, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Dennis Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Teresa B. O'Donoghue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John J. Dolan</u> <u>1323 30th Street NW Washington, DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Thrombotic Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>45</u> , to <u>Apr 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>57</u> , and that death occurred at <u>4:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Stuart Lyddane</u>				ADDRESS (Street, city or town, state) <u>3066 Que St. N.W. Wash D.C.</u> DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>E. STUART LYDDANE, MD</u>				3066 Que Street NW, Washington, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Baulers</u>				ADDRESS <u>1752 Pa. Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE 3-6-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>			

BUREAU A. S.

MAR 8 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03081

## CERTIFICATE OF DEATH

03055

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4711 Essex Avenue</b>				d. STREET ADDRESS <b>4711 Essex Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Louise</b>		First <b>M.</b> Middle <b>DONCH</b> Last		4. DATE OF DEATH <b>March 25</b>		Day <b>19</b> Year <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1865</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>11</b> Days <b>24</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Music teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Donch</b>				14. MOTHER'S MAIDEN NAME <b>Elise Brand</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Lillian A. McNish-Same Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis, general</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>20 yrs</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>50</b> , to <b>25 Mar</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>25 March</b> , 19 <b>57</b> , and that death occurred at <b>1:00 p.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. J. Coleman</b> M.D. <b>1957</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Francis T. Coleman, M.D.</b>				<b>5315 - 16th St. N. W. Wash. D. C. 3/25/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</b>				24a. REC'D BY REGISTRAR <b>28-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

BUREAU V. S.

APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03056

03029

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANATARIUM</u>		d. STREET ADDRESS <u>720-PEABODY ST NW</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Dreifus</u> Last <u>Dreifus</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>19</u> - Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2<sup>nd</sup> 1897</u> 79 yrs.
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired, Businessman.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Isac Dreifus.</u>		14. MOTHER'S MAIDEN NAME <u>EVA MAIER.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Julius Dreifus</u>		Address <u>same as patient</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate gland</u> <u>177X</u> DUE TO <u>metastasis into the pelvic area</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized cachexia and malnutrition</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3-15</u> , 19 <u>57</u> , to <u>3-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-19</u> , 19 <u>57</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>VERONIKA TROOST</u>		M.D. <u>10401 New Hampshire Ave. - Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>VERONIKA TROOST M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-20-1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>MT LEBANON</u>		22d. LOCATION (City, town, or county) (State) <u>HATTSVILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danganeky &amp; SONS</u>		ADDRESS <u>3501-14<sup>th</sup> ST NW</u>	
24a. REC'D BY REGISTRAR <u>3/21/57</u>		DATE <u>3/21/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Veronica Troost</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE		ALABAMA		U.S.A.		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1945		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
EDUCATION		SCHOOL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HIGH SCHOOL		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	
OCCUPATION		BUSINESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
BUSINESS		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	
CAUSE OF DEATH		DISEASE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HEART DISEASE		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	
MANNER OF DEATH		NATURAL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
NATURAL		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	
DATE OF DEATH		1968		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
1968		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	
PLACE OF DEATH		HOSPITAL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HOSPITAL		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	
DATE OF REPORT		1968		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
1968		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	
REPORTED BY		DOCTOR		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
DOCTOR		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	
SIGNATURE		DOCTOR		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
DOCTOR		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		U.S.A.	

BUREAU V. B.

MAR 22 1967

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03082

## CERTIFICATE OF DEATH

Reg. Dist. No.

03057

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5032 Bradley Blvd - Apt 7</u>				d. STREET ADDRESS <u>5032 Bradley Blvd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Paul Horkan Drury</u>				4. DATE OF DEATH <u>March 24 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 20 1917</u>	
9. AGE (In years last birthday) <u>40 yrs.</u>		IF UNDER 1 YEAR <u>3</u> Months <u>4</u> Days <u>4</u> Hours <u>Min.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real estate broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>broker</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Peter A. Drury</u>		14. MOTHER'S MAIDEN NAME <u>Joan Walsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>LORETTA O. DRURY</u>		17. INFORMANT <u>Loretta O. Drury</u>		Address <u>5032 Bradley Blvd - Bethesda</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>345X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Central Respiratory Failure</u> DUE TO (c) <u>Multiple Sclerosis (C.M.S.)</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1955</u> to <u>March 1957</u> , that I lost saw the deceased alive on <u>March 23 1957</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED <u>3/26/57</u>			
ACTUAL SIGNATURE <u>Leo I. Donovan</u> M.D. <u>8016 Georgetown Rd.</u>				PHYSICIAN'S NAME (Type) <u>Leo I. Donovan, MD.</u> <u>8016 Georgetown Rd. Beth 14, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Montg. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>3-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bea M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

03032

APR 1 1957

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03058

Reg. Dist. No. 216

03083

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>151 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lancaster 75 X-3</b> c. STREET ADDRESS <b>620 North Queen Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>Eugene</b> Last <b>Duffy</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4th,</b> Year <b>19 57</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22nd, 1885</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>12</b> Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rug making</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			
13. FATHER'S NAME <b>Albert Duffy</b>			14. MOTHER'S MAIDEN NAME <b>Rebecca Fisher</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>186-09-1778</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain abscess &amp; metastatic cancer from 160X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of left maxillary antrum.</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>lyrot</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 4th, 19 56</b> to <b>March 4th, 19 57</b> , that I last saw the deceased alive on <b>March 4th, 19 57</b> , and that death occurred at <b>1:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>R. W. Weiger, M.D.</b> <b>The Clinical Center</b> <b>3/4/57</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>3/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Eden Lutheran</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>3-6-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

RECEIVED

MAR 8 1957

**BUREAU**

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03084

CERTIFICATE OF DEATH

Reg. Dist. No.

03059

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, DC</u> 47X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL HALL REST HOME</u>				d. STREET ADDRESS <u>505-DECATUR ST. NW.</u>			
3. NAME OF DECEASED (Type or print) First <u>ELLIS</u> Middle <u>-</u> Last <u>DUKE</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-7-1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SOFT DRINK</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>	
13. FATHER'S NAME <u>ABRAHAM DUKE</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-18-02</u>		17. INFORMANT <u>HERBERT DUKE</u> Address <u>WV-5 Ross Rd S. 15c MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Senility</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma - Lg. Bowel - Resected 1954 - WARD. D.S.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>8/2/56</u> , 19____, to <u>3/31/57</u> , 19____, that I last saw the deceased alive on <u>3/30/57</u> , 19____, and that death occurred at <u>5:05 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sam Allen</u> M.D. <u>Kensington, Md.</u>				DATE SIGNED <u>3/31/57</u>			
PHYSICIAN'S NAME (Type) <u>SAM ALLEN</u> M.D. <u>Kensington, Md.</u>				DATE <u>3/31/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR-2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hallock Funeral Home</u> ADDRESS <u>4217 2nd St NW</u>				24a. REC'D BY REGISTRAR <u>4/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>James Collier</u>	

CERTIFICATE OF DEATH

Form 100-10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		12-1-22		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL		CITY	
APR 4 1968		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		APR 6 1968		BALTIMORE		BALTIMORE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY		STATE		COUNTRY		DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY	
APR 8 1968		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		APR 8 1968		BALTIMORE		BALTIMORE	

BUREAU V. 3

APR 8 1968

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03060

# CERTIFICATE OF DEATH

03085

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>XO Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5325 Baltimore Ave.</u>				STREET ADDRESS <u>5325 Baltimore Ave.,</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Roy</u> <u>Dunn</u> <u>Dunn</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>22</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 10, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>		IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchandising - Dept. Store</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dyran A. Dunn</u>				14. MOTHER'S MAIDEN NAME <u>Ida Saunders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. John R. Lynch, Son-in-law</u> <u>5325 Balt. Ave., Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion, multiple</u>				<u>6 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary sclerosis, advanced</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Previous multiple myocardial infarctions</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>    </u>		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1949</u> , to <u>March 22, 1957</u> , that I last saw the deceased alive on <u>3-22-57</u> , 19 <u>57</u> , and that death occurred at <u>3:00 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stewart Blapp</u>				ADDRESS (Street, city, town, state) <u>3921 Ingomar St. N.W. Wash D.C.</u>		DATE SIGNED <u>3-22-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>3/25-Burial</u>		DATE THEREOF <u>3/25/57</u>		NAME OF CEMETERY OR CREMATORY <u>Knollwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cleveland, Ohio</u>	
24. REC'D BY REGISTRAR DATE <u>3/27/57</u>		REGISTRAR'S SIGNATURE <u>Benni M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chose Friend</u>		ADDRESS <u>5103 Wis. Ave., N.W. Wash. D.C.</u>	

# CERTIFICATE OF DEATH

3082

1. DEATH CERTIFICATE NUMBER

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. RACE

15. COLOR

16. HEIGHT

17. WEIGHT

18. BUILD

19. COMPLEXION

20. HAIR

21. EYES

22. MOUTH

23. NOSE

24. EARS

25. TEETH

26. SKIN

27. FINGERS

28. TOES

29. NAILS

30. OTHER

BUREAU V. S.

APR 1 1957

RECEIVED

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03086

## CERTIFICATE OF DEATH

03061

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>185 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> 47X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Wentzel</b> Middle <b>During</b> Last <b>Du Plessis</b>		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1957</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 26, 1935</b>		9. AGE (In years last birthday) yrs. <b>21</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Holland</b>				12. CITIZEN OF WHAT COUNTRY? <b>South Africa</b> ✓			
13. FATHER'S NAME <b>Wentzel C. Du Plessis</b>						14. MOTHER'S MAIDEN NAME <b>Marie During</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Increased intracranial pressure</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hemorrhage</b> DUE TO (c) <b>unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>36 hours</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy - post operative</b>															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>September 27, 1956</b> to <b>March 31, 1957</b> , that I last saw the deceased alive on <b>March 31, 1957</b> , and that death occurred at <b>4:40 A.M.</b> from the causes and on the date stated above.															
ACTUAL SIGNATURE <b>Robert Gordon Long</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>				DATE SIGNED <b>3/31/57</b>							
PHYSICIAN'S NAME (Type) <b>Robert Gordon Long, M.D.</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				22b. DATE THEREOF <b>4/1/57</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>				22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company-Washington, D.C.</b>								ADDRESS <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>APR 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

APR 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03062

03056

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>6 weeks</u>				d. STREET ADDRESS <u>6120 Temple Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sally Amanda Edgar</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/21/1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia Athens</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin Bray</u>				14. MOTHER'S MAIDEN NAME <u>MacMillian</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-44-7612A</u>		17. INFORMANT <u>Mrs. Joanne Metzner</u> Address <u>6120 Temple St. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>331X</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>years</u> DUE TO (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 13</u> , 19 <u>57</u> , to <u>March 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 17</u> , 19 <u>57</u> , and that death occurred at <u>9: A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Allen J. O'Neill</u>				ADDRESS (Street, city or town, state) <u>8601 old Georgetown Rd, Bethesda Md.</u>			
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>				DATE SIGNED <u>March 18, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Belmar Manor, Md. Pr. Geo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>71 alley's Funeral Home Inc.</u>				ADDRESS <u>3200-R.I. Ave.</u>		24a. REC'D BY REGISTRAR <u>MAR 21 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Lamell Krayton</u>							



BUREAU V. 1

MAR 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film 6212 3-19-51 et

03063

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>4722-47th N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp. 8600 Old Georgetown Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emily Eberhardt</u>		4. DATE OF DEATH Month Day Year <u>March 6 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 13 1867</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Schohl, Joseph</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Schohl, Walter</u>		Address <u>4722-47th St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>903.0 Acute congestive heart failure &amp; shock</u> DUE TO (b) <u>Fracture of left hip</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor of her home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:30</u> p.m. <u>3-21</u> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>D.C.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Constitutional Cem.</u>		22d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chou Inn</u>		ADDRESS <u>5103 11th Ave N.W.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF WITNESS _____		SIGNATURE OF CORONER _____	
CITY _____		COUNTY _____		STATE _____	

BUREAU V. S.

MAR 13 1957

RECEIVED

03088

## CERTIFICATE OF DEATH

03064

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). o. STATE <b>District of Columbia</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>39 hr. 39 min.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>			d. STREET ADDRESS <b>4311 Overlook Ave., S.W.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Elaine</b> Last <b>ELDRIDGE</b>			4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 March 1957</b>		9. AGE (In years last birthday) yrs. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Thomas G. Eldredge</b>			14. MOTHER'S MAIDEN NAME <b>Diane Gertrude Robins</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>(Father) Thomas G. Eldredge (Same As #2)</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART BLOCK, CON GENITAL</b> <b>754.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>INDEFINITE</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>24 March</b> , 19 <b>57</b> , to <b>26 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>26 March</b> , 19 <b>57</b> , and that death occurred at <b>3:10 P.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Daniel Shunter</b>			ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 3-27-57</b>		
PHYSICIAN'S NAME (Type) <b>Daniel Shunter, LT, MC, USN</b>			<b>U.S. Naval Hospital, Bethesda, Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-29-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>3-27-57</b>		
			24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051252XV3

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MAR 29 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03089

## CERTIFICATE OF DEATH

04217

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>3 YRS</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3507 HARRELL STREET</b>				d. STREET ADDRESS <b>3507 HARRELL STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>CHARLES</b> Last <b>EVANS</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/72</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>		11. BIRTHPLACE (State or foreign country) <b>UTAH</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK H. EVANS</b>				14. MOTHER'S MAIDEN NAME <b>EMMA RAYMOND</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Ruth E. Yashko, 3507 Harrett St. Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 23, 1957</b> , to <b>March 30, 1957</b> , that I last saw the deceased alive on <b>March 29, 1957</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Michael R. Dobridge</b>				ADDRESS (Street, city or town, state) <b>10620 Georgia Ave. Silver Spring, Md.</b>		DATE SIGNED <b>March 30, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Michael R. Dobridge</b>							
22a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>3/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LOGAN CITY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>LOGAN, UTAH</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>4/5/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For burial, cremation, or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03065  
214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANGLEY PARK, HYATTSVILLE 16152</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FLOWER DELICATESSEN, 8707 FLOWER AVE.</b>				d. STREET ADDRESS <b>8230 14th AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DAVID</b> <b>FEINSTEIN</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 20, 1895</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>ELIAS FEINSTEIN</b>				14. MOTHER'S MAIDEN NAME <b>PESYAH GOLINOFKY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give way or dates of service) <b>WW #1</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Ida Feinstein, 8230 14th Ave., Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>3/28/57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>MAR. 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>OXEN HILL MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY + SONS</b>				ADDRESS <b>3501-14 ST. NW</b>		24a. REC'D BY REGISTRAR <b>APR 3 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>			

APR 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03066

03091

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>2480 - 16th St. N.W.</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>5721 Grosvenor Lane</u>				d. STREET ADDRESS <u>2480-16th St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>F.</u> Last <u>Finucane</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22 1897</u> 59 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Francis Finucane</u>				14. MOTHER'S MAIDEN NAME <u>Norah Josephine</u>			
15. WAS OR EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Dr. Finucane - brother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u> <u>5 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9045 FRACTURE OF HIP IN NOV. 1956.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL ON STREET IN WASH. D.C.</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>Nov 19 56</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>March 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 29</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Dessoff</u>				ADDRESS (Street, city or town, state) <u>1302-18th St. N.W. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL DESSOFF</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>3012 M-N.W. Wash.</u>		24a. REC'D BY REGISTRAR <u>APR 1 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			



**BUREAU**

APR 1 1957

RECEIVED

03092

## CERTIFICATE OF DEATH

03067

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>District of Columbia</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>138 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>713 "D" Street, S. E.</b>							
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Lucille</b> Last <b>Foley</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1898</b>	
9. AGE (In years lost birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Andrew J. Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Allie White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of breast metastasized to</b> DUE TO <b>liver, adrenals, bone, dura, and lung</b> (c) <b>liver, adrenals, bone, dura, and lung</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>9 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 8, 1956</b> , to <b>March 26, 1957</b> , that I last saw the deceased alive on <b>March 26, 1957</b> , and that death occurred at <b>4.10 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/26/57</b>							
ACTUAL SIGNATURE <b>Samuel Charache</b> M.D.				PHYSICIAN'S NAME (Type) <b>Samuel Charache, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) <b>Arlington Va.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home</b>				ADDRESS <b>Washington D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>3-28-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		1957	
Place of Birth		Age at Death	
Washington		38 days	
Sex		Race	
Male		White	
Marital Status		Cause of Death	
Single		Heart Disease	
Occupation		Place of Death	
Teacher		Home	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 5

APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03093

## CERTIFICATE OF DEATH

03068

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>South Arlington 83x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>				d. STREET ADDRESS <b>3817 South 9th Street,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Monroe</b> Last <b>FROST</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Oct. 1899</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.M.C. (Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Charles Frost</b>				14. MOTHER'S MAIDEN NAME <b>Ann Gerhardt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1921 to 1932</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>(Sister) Mildred E. Abel (Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculosis - far advanced active pulmonary</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>chronic fibro-cystic lung disease with emphysema</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>(County) (State)</b>							
21. I certify that I attended the deceased from <b>28 February, 19 57</b> , to <b>1 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1 March</b> , 19 <b>57</b> , and that death occurred at <b>4:10 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harold I. Passes</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Maryland</b>			
DATE SIGNED <b>3-2-57</b>							
PHYSICIAN'S NAME (Type) <b>Harold I. Passes, LT, MC, USNR</b>				U.S. Naval Hospital, Bethesda, Md. <b>3-2-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-5-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>IVES Funeral Home</b>				ADDRESS <b>2847 Wilson Blvd. Arl. Va.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-2-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Betty E. Parrelly</b>							

**BUREAU V. S.**

MAR 6 1957

RECEIVED



03030

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. &amp; HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CARLOS</b> Middle <b>LEE</b> Last <b>GARTRELL</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 27, 1924</b>	9. AGE (In years last birthday) yrs. <b>32</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAWYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>SILVER SPRING, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STEPHEN GARTRELL</b>				14. MOTHER'S MAIDEN NAME <b>HELEN CHANEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW # 11</b>		17. INFORMANT <b>Mrs. Eugenia R. Gartrell, 923 Northampton Dr. Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Dec 18, 1956</b> , to <b>March 23, 1957</b> , that I last saw the deceased alive on <b>March 23, 1957</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Maryland</b> DATE SIGNED <b>3/23/57</b>							
ACTUAL SIGNATURE <b>John J. Curry</b>		M.D. <b>10620 Georgia Ave Silver Spring, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/25/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MORGAN CHAPEL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WOODBINE, CARROLL COUNTY, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wanner E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 3/25/57</b>	24b. REGISTRAR'S SIGNATURE <b>William D. D. D.</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

03094 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03070

218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>19 hrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montg. Co. Gen</b>			d. STREET ADDRESS <b>611 Stonestreet Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter Geddings</b>			4. DATE OF DEATH Month Day Year <b>March 18 19 57</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/1934</b>		9. AGE (In years last birthday) <b>23</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Walter Geddings</b>			14. MOTHER'S MAIDEN NAME <b>Nellie Florence</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gas Infection</b> DUE TO 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shot gun wound in abdomen</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>27 hrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>shot in abdomen</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>2:00x 3/16 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>farm</b>	
		20f. (City or town) <b>Gaithersburg</b>		(County) <b>Montg.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/18/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>	
				22d. LOCATION (City, town, or county) (State) <b>Mt. Zion, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>			ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>26 1957</b>
			24b. REGISTRAR'S SIGNATURE <b>Bertrude Lowery</b>		

RECEIVED

MAR 26 1957

BUREAU V. 3

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe  
2. Age: 45  
3. Sex: Male  
4. Race: White  
5. Date of Death: March 25, 1957  
6. Place of Death: New York City  
7. Cause of Death: Heart Disease  
8. Manner of Death: Natural  
9. Signature of Medical Examiner: [Signature]  
10. Signature of Coroner: [Signature]  
11. Signature of Registrar: [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03071

03095

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47x-3</b>			
c. LENGTH OF STAY IN 1b <b>one day</b>				d. STREET ADDRESS <b>3200 38th St., N.W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Edward</b> Middle <b>Banks</b> Last <b>GIBSON</b>		4. DATE OF DEATH		Month <b>March</b> Day <b>31</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 April 1888</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR: Months <b>31</b> Days <b>19</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert Banks Gibson</b>				14. MOTHER'S MAIDEN NAME <b>Ella Banks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 6-25-06 to 6-1-31</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>(Wife) Mrs. Sallie Peirce Gibson (Same as #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive heart failure</b> DUE TO (c) <b>Hypertensive arteriosclerotic cardiovascular disease</b> <b>2</b> <b>years.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriovenous Thrombosis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>31 March</b> , 19 <b>57</b> to <b>31 March 1957</b> , that I last saw the deceased alive on <b>31 March</b> , 19 <b>57</b> , and that death occurred at <b>6:15 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Russell Miller, Jr. LT(MC)USN</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-1-57</b>			
PHYSICIAN'S NAME (Type) <b>RUSSELL MILLER, JR. LT, MC, USN</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>4-1-57</b>		24b. REGISTRAR'S SIGNATURE <b>Wesley E. Russell</b>	



RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03072

03096

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4401 East-West Highway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>AGNES J. GOLUMBUSKI</b>				4. DATE OF DEATH <b>March 15, 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 21, 1870</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>24</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Andrew Moskwa</b>				14. MOTHER'S MAIDEN NAME <b>Anna Adamczyk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Anne A. Gelumbis-Item# 2</b>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>3/4</b> , 19 <b>57</b> , to <b>3-15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/15/</b> , 19 <b>57</b> , and that death occurred at <b>2 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>Mch 16, 1957</b>							
ACTUAL SIGNATURE <b>Paul D. Cantor</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Paul D. Cantor</b>			<b>4709 Montgomery Lane, Bethesda, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>		22b. DATE THEREOF <b>3/18/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>New Castle Co. Delaware</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</b>			ADDRESS <b>7557 Wis. Ave. Bethesda, Md</b>		24a. REC'D BY REGISTRAR <b>3-18-57</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

CERTIFICATE OF DEATH

Name of Deceased		MONTGOMERY, Benjamin	
Date of Birth		January 31, 1870	
Place of Birth		New York City, New York	
Sex		Male	
Race		Caucasian	
Marital Status		Married	
Spouse's Name		MONTGOMERY, Mary	
Occupation		None	
Cause of Death		Heart Disease	
Date of Death		March 21, 1957	
Place of Death		New York City, New York	
Physician's Name		Dr. J. H. Smith	
Hospital Name		St. Mary's Hospital	
Burial Place		St. Mary's Cemetery	
Burial Date		March 23, 1957	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. S.

MAR 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
03031 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 7, 10a FilmG213 4-8-57 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

03073

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>		d. STREET ADDRESS <u>10703 St Margaret's Way</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Shirley Grandskaff</u>		4. DATE OF DEATH Month Day Year <u>3 28 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-68</u>
9. AGE (In years last birthday) <u>89 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph B Grandskaff</u>		14. MOTHER'S MAIDEN NAME <u>Louise Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia State</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>10 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 17, 1957</u> to <u>March 28, 1957</u> that I last saw the deceased alive on <u>March 27, 1957</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Whitely</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carrollton</u> DATE SIGNED <u>3-28-57</u>	
PHYSICIAN'S NAME (Type) <u>Takoma Park, 12, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edge Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Charlestown, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Humphrey</u> ADDRESS <u>7557 Wisconsin Ave</u>		24a. REC'D BY REGISTRAR DATE <u>3/30/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>John R. Ridd</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF NOTARY	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF BURIAL	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

APR 2 1957

RECEIVED



03097

## CERTIFICATE OF DEATH

03074

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>111 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>1911 East West Highway</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Marilyn</b> Middle <b>(none)</b> Last <b>Greene</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1925</b>		9. AGE (In years lost, birthday) yrs. <b>31</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gustav Steiner</b>				14. MOTHER'S MAIDEN NAME <b>Bess Leiner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>047-12-0105</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Decompensation</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic carcinoma of Breast</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>November 15, 1956</b> to <b>March 6, 1957</b> , that I last saw the deceased alive on <b>March 6, 1957</b> , and that death occurred at <b>9:43 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William J. Pieper</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/6/57</b>			
PHYSICIAN'S NAME (Type) <b>William J. Pieper, M. D.</b>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>MARCH 8, 1957 LINDEN HILL</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>NEW YORK</b>		22d. LOCATION (City, town, or county) (State) <b>N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS 3501-1402 NW</b>				24a. REC'D BY REGISTRAR <b>DATE 3-11-57</b>		24b. REGISTRAR'S SIGNATURE <b>Beattie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH  
 - 13087 -  
 CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death	
Theodore J. ...		45		Male		White		1911		1957		Boston, Mass.		Heart Disease	
Residence		Occupation		Marital Status		Education		Previous Illnesses		Last Illness		Physician		Burial Place	
123 Main St.		Teacher		Married		High School		None		Heart		Dr. J. ...		Catholic	
Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Family		Signature of Witness		Signature of Minister		Signature of Coroner		Signature of Burial Officer	
J. ...		M. ...		T. ...		W. ...		A. ...		C. ...		D. ...		E. ...	

**RECEIVED**  
 MAR 13 1957  
 BUREAU V. S.

03098

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Montana</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>7 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Ross</u> Last <u>GREENING</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-14</u>		9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aviator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles W. Greening</u>				14. MOTHER'S MAIDEN NAME <u>Jewell Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, June 1936 to 3-29-57</u>		16. SOCIAL SECURITY NO. <u>483 48 4247</u>		17. INFORMANT Address <u>(Wife) Mrs. Dorothy W. Greening (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, complication of operation for -</u> DUE TO <u>430.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic</u> DUE TO <u>1 yr.</u> (c) <u>Bacterial Endocarditis</u> DUE TO <u>2 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>31 Aug.</u> 19 <u>56</u> , to <u>29 March</u> 19 <u>57</u> , that I last saw the deceased alive on <u>28 March</u> 19 <u>57</u> , and that death occurred at <u>4:00 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D.P. Osborne</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 3-29-57</u>			
PHYSICIAN'S NAME (Type) <u>D.P. OSBORNE, CDR, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>DATE 3-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Darrell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03099

## CERTIFICATE OF DEATH

03076

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <i>Mont.</i> <i>14326 Colesville Rd</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md</i> c. LENGTH OF STAY IN 1b <i>9 mo.</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mrs. Green's Nursing Home</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Wash.</i> b. COUNTY <i>D.C.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X-3</i> d. STREET ADDRESS <i>4326 3rd N.W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Cynthia</i> Middle <i>(None)</i> Last <i>Gritton</i>		4. DATE OF DEATH Month <i>Mar.</i> Day <i>22</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3 July 1868</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Danville Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Patrick Daley</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>John S. Mansuy 9110 Bradford Rd Silver Spring</i>	
17. INFORMANT <i>John S. Mansuy</i>		Address <i>9110 Bradford Rd Silver Spring</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>443X Acute congestive heart failure</i> DUE TO (b) <i>Hypertensive heart disease</i> DUE TO (c) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>36</i> to <i>22 Mar</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>22 March</i> , 19 <i>57</i> , and that death occurred at <i>9 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas E. Mattingly M.D.</i>		ADDRESS (Street, city or town, state) <i>2200 R.I. Ave N.E. Wash D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Thomas E. Mattingly M.D.</i>		DATE SIGNED <i>22 March 57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>3-25-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Int. Olivet</i>	22d. LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lee Son</i>		ADDRESS <i>-Wash. D.C.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>	
DATE <i>3/26/57</i>			



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. B.

MAR 27 1957

RECEIVED

Ward D.C.

Ward D.C. - 3-5225 Jnt. (last)

03100

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6911 Strathmore St.</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>GALLAHER</u> Last <u>HALE</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>William Gallaher</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Ainsworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>R.D. Hale-735 West Ave.-Cartersville, Ga.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstructive jaundice due to metastatic carcinoma of the liver &amp; biliary system.</u> 199.9 DUE TO <u>Primary site unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>March 17, 1957</u> , to <u>March 21, 1957</u> , that I last saw the deceased alive on <u>March 21, 1957</u> , and that death occurred at <u>1 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur F. Woodward</u> M.D. <u>Rockville - Md.</u>				ADDRESS (Street, city or town, state) <u>Rockville - Md.</u>			
DATE SIGNED <u></u>							
PHYSICIAN'S NAME (Type) <u>Arthur F. Woodward-Rockville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>3/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West View</u>		22d. LOCATION (City, town, or county) (State) <u>Atlanta, Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>8-25-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

MAR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03101

CERTIFICATE OF DEATH

03078

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>William</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/10/19</b>		9. AGE (In years last birthday) <b>37</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Chester Hall</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Marr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Record</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Adrenal</b> 145X DUE TO <b>Carcinoma of Adrenal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Nov</b> , 19 <b>56</b> , to <b>14 Mar</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>13 Mar</b> , 19 <b>57</b> , and that death occurred at <b>8:04 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>C. H. Ligon, M. D.</b>				PHYSICIAN'S NAME (Type) <b>Sandy Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wash Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>3-17-57</b>		24b. REGISTRAR'S SIGNATURE <b>Subin B. Lawley</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p><b>DECEASED</b></p> <p>NAME: <i>Robert B. [illegible]</i></p> <p>AGE: <i>45</i> YEARS</p> <p>SEX: <i>Male</i></p> <p>RACE: <i>White</i></p> <p>DATE OF BIRTH: <i>1912</i></p> <p>DATE OF DEATH: <i>1957</i></p> <p>PLACE OF DEATH: <i>Home</i></p> <p>Cause of Death: <i>Heart Disease</i></p> <p>Physician: <i>[Signature]</i></p> <p>Signature of Deceased: <i>[Signature]</i></p> <p>Signature of Next of Kin: <i>[Signature]</i></p> <p>Signature of Medical Examiner: <i>[Signature]</i></p> <p>Signature of Registrar: <i>[Signature]</i></p>		<p><b>REPORTING PHYSICIAN</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>
<p><b>DECEASED'S RESIDENCE</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S OCCUPATION</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S MARRIAGE</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S EDUCATION</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S RELIGION</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S SERVICE</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S INTERESTS</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S DEPENDENTS</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S BURIAL</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S CREMATION</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		
<p><b>DECEASED'S OTHER INFORMATION</b></p> <p>NAME: <i>[illegible]</i></p> <p>ADDRESS: <i>[illegible]</i></p> <p>CITY: <i>[illegible]</i></p> <p>STATE: <i>[illegible]</i></p> <p>DATE: <i>[illegible]</i></p>		

BUREAU V. 2

MAR 21 1957

RECEIVED



03102

## CERTIFICATE OF DEATH

03079

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		c. LENGTH OF STAY IN lb <b>41 days</b>		d. STREET ADDRESS <b>2228 - 40th Place, N. W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Sidney</b> Last <b>Hawkins</b>		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 57</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 21, 1900</b>		9. AGE (In years last birthday) <b>56</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Renegotiation Board</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>	
13. FATHER'S NAME <b>John Sidney Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Willie Lou Gibbs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro intestinal bleeding</b> 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>4 mos</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Lower Lobe Atelectasis; Multiple Abscesses</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Waco</b>	(County) (State)
21. I certify that I attended the deceased from <b>February 18</b> , 19 <b>57</b> , to <b>March 31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 31</b> , 19 <b>57</b> , and that death occurred at <b>8.30 A.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>John Laszlo</b>		M.D. <b>The Clinical Center</b>		DATE SIGNED <b>3/31/57</b>	
PHYSICIAN'S NAME (Type) <b>John Laszlo, M.D.</b>		ADDRESS <b>National Institutes of Health Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/2/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waco Texas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Samois Sone</b>		ADDRESS <b>1756 Pennsylvania Ave NW, Washington, DC</b>		24a. REC'D BY REGISTRAR <b>DATE 4-8-57</b>	24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

APR 5 1957

RECEIVED

03032

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>			c. LENGTH OF STAY IN 1b <u>13 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>			d. STREET ADDRESS <u>Silver Spring 56</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ANNA CATHERINE HEIM</u>			4. DATE OF DEATH <u>March 25 1957</u>		
5. SEX <u>female</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>7-19-80</u>		
9. AGE (In years last birthday) <u>76</u> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>Gustav E. Rott</u>			14. MOTHER'S MAIDEN NAME <u>Ida MARY HARTIG</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>Mrs Carl F. Crezee</u>			Address <u>SS., Md. 8007 Park Crest Dr.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> <u>581.0</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>March 1953</u> to <u>Mar. 25, 1957</u> , that I last saw the deceased alive on <u>Mar. 25, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>C. Willard Camahier, Jr.</u> M.D.			ADDRESS (Street, city or town, state) <u>1801 Eye St. N. W. Wash. 6, D.C.</u>		
DATE SIGNED <u>3/25/57</u>					
PHYSICIAN'S NAME (Type) <u>C. WILLARD CAMAHIER, JR.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner &amp; Rumphrey</u>			ADDRESS <u>8434 Ga Ave SS Md.</u>		
24a. REC'D BY REGISTRAR <u>3/29/57</u>			24b. REGISTRAR'S SIGNATURE <u>John R. Bell</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 2 1957

RECEIVED

03103

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY <b>47x-3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C. 47x-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Rest Home</b>				d. STREET ADDRESS <b>1325 Longfellow St., N. W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>GLADYS</b>		First <b>E.</b>		Middle <b>HENDERSON</b>		Last <b>March 8,</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <b>March 8,</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		11. BIRTHPLACE (State or foreign country) <b>US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>R. Milton Henderson</b>		14. MOTHER'S MAIDEN NAME <b>Lilly Petrola</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Rebecca A. Sibley</b>		Address <b>3907 Aspen St.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>356.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition</b> (c) <b>Amyotrophic Lateral Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>6 mo.</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1/23, 1956</b> , to <b>3/8, 1957</b> , that I last saw the deceased alive on <b>3/8, 1957</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Jagers</b> M.D.				ADDRESS (Street, city or town, state) <b>5707 Wis. Ave., Chevy Chase, Md.</b>			
DATE SIGNED <b>3/9/57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3-11-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
March 15, 1957		Boston, Mass.		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:30 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 18 1957

RECEIVED

Robert A. Murphy-Bernard, D.O.  
3/11/57  
Confidential

## 03104 CERTIFICATE OF DEATH

03082

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>Montrose Ave., Parkside Apts.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Kenneth</b> Middle <b>L.</b> Last <b>Henderson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 21, 1902</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Merchandising</b>		11. BIRTHPLACE (State or foreign country) <b>White Plains, N. Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>Henry C. Henderson</b>				14. MOTHER'S MAIDEN NAME <b>Annie Randell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-36-5285</b>		17. INFORMANT <b>Wife</b> <b>Ruth A. Henderson</b>	
Address <b>Parkside Apts. Montrose Ave, Bethesda Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-renal failure</b> <b>420.1</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Generalized marked arterio sclerosis indefinite</b> (b) <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 day</b> <b>Sys.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b></b>				20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that I attended the deceased from <b>March 1956</b> to <b>March 2, 1957</b> , that I last saw the deceased alive on <b>Mar 2, 1957</b> , and that death occurred at <b>3:35 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert G. Taylor</b>				ADDRESS (Street, city or town, state) <b>The Washington Clinic</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT G TAYLOR</b>				DATE SIGNED <b>Washington 15 Dec</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 3-7-57</b>		22b. DATE THEREOF <b>3-7-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Kenisco Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westchester County, N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R A Humphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>8-5-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 03083 214										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47X-3</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cedarcroft Sanatorium</b>					d. STREET ADDRESS <b>4209 41st N.W.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Higgins</b> Last <b>Higgins</b>					4. DATE OF DEATH Month <b>Mar.</b> Day <b>2</b> Year <b>1957</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 1, 1913</b>		9. AGE (In years last birthday) <b>44</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Thomas J. Hoy</b>					14. MOTHER'S MAIDEN NAME <b>Mary Barteman</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Laurence Higgins Same as Item 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to vomitus</b> <b>322.2</b> DUE TO <b>(pending)x Alcoholism</b> Conditions, if any, which gave rise to immediate cause (b) (c) <b>Alcoholism</b> DUE TO <b>Alcoholism</b> (a) stating the underlying cause last.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour <b>o. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Frank J. Broschart</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>2-6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>					ADDRESS <b>3821-14th N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>3/5/57</b>		24b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>	

# STATE DEPARTMENT OF HEALTH-BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR. 7, 1957

RECEIVED



03033

CERTIFICATE OF DEATH

03084

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. + Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md</u> d. STREET ADDRESS <u>5902 Kingwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ida Jeannette</u> First Middle Last 4. DATE OF DEATH <u>March 17</u> Month Day Year <u>1957</u>			5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-14-91</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Perry</u>				14. MOTHER'S MAIDEN NAME <u>Sadonia Biggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chas</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of the breasts</u> DUE TO (c) <u>1 year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/19/57</u> , to <u>3/17/57</u> , that I last saw the deceased alive on <u>3/17/57</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3/17/57</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Chas H Wilo Hon</u> M.D.				PHYSICIAN'S NAME (Type) <u>Chas H Wilo Hon</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Spottsylvania County, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>3/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

*Generalized carcinoma  
of the stomach*

*6 mo  
after*

BUREAU V. 2

MAR 20 1957

RECEIVED

03034 CERTIFICATE OF DEATH

Reg. Dist. No. 223

03085

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D. C.</i> b. COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>10 hrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>				d. STREET ADDRESS <i>607 Whittier St., N.W.</i>			
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>Salina</i> Last <i>Hogge</i>				4. DATE OF DEATH Month <i>3</i> Day <i>11</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>3-6-72</i>	
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months <i>11</i> Days <i>19</i> Hours <i>57</i> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James Seawell</i>				14. MOTHER'S MAIDEN NAME <i>Mary Cavann</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Washington Sanitarium &amp; Hospital Park</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage massive into stomach</i> <i>540.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Peptic ulcer, chronic, active, stomach</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis &amp; old healed infarct of myocardium</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <i>a. m.</i> <i>19</i> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>10/11/1955</i> to <i>March 11, 1957</i> , that I last saw the deceased alive on <i>March 11, 1957</i> , and that death occurred at <i>10:55 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Dean H. Harding</i> M.D.				ADDRESS (Street, city or town, state) <i>113 Carroll St NW, Wash 12, DC</i>			
PHYSICIAN'S NAME (Type) <i>DEAN H. HARDING</i>				DATE SIGNED <i>3/11/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 14, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Providence Baptist Church Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Gloucester County, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>				ADDRESS <i>254 Carroll St NW DC</i>		24a. REC'D BY REGISTRAR DATE <i>3/13/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. Arthur Walters</i>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		RACE		ETHNICITY		MANNER OF DEATH		CAUSE OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CERTIFICATE NO.		REGISTERED	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF NOTARY		SIGNATURE OF CORONER		SIGNATURE OF SHERIFF	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		CERTIFICATE NO.		REGISTERED	

BUREAU V. S.

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03086

03106

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AUGUST</u> Middle <u>A.</u> Last <u>HOLZNER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-1887</u>	9. AGE (In years lost birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MELT NATCHMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD. UNIVERSITY</u>		11. BIRTHPLACE (State or foreign country) <u>RHODE ISLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>NOT AVAILABLE</u>				14. MOTHER'S MAIDEN NAME <u>NOT AVAILABLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-22-1135</u>		17. INFORMANT <u>MRS. AMELIA T. HOLZMER</u>		Address <u>(SAME AS #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemiplegia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of bladder</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 7, 1954</u> , to <u>March 15, 1957</u> , that I last saw the deceased alive on <u>March 15, 1957</u> , and that death occurred at <u>3:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D.				8237 Georgia Avenue, Silver Spring, Md.			
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum, M. D.</u>				March 16, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 19-1957</u>		<u>Forest Hill Cemetery</u>		<u>Leggs Road - Hyattsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll Dr. NW</u>			
24a. REC'D BY REGISTRAR <u>MAR 18 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			



**BUREAU V. S.**

MAR 19 1957

RECEIVED

03107

CERTIFICATE OF DEATH

03087

Reg. Dist. No.

217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Silver Spring RFD #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>KANSAS AVENUE</u>			
3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>SMITH</u> Last <u>HOOD</u>				4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-10</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>ISSAC YOUNG</u>				14. MOTHER'S MAIDEN NAME <u>LOTTIE FISHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>George (husband) RFD #1 Silver Spring Md</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO <u>Chronic Pulmonary Tuberculosis and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Chronic Tuberculosis Peritonitis</u> (b) <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>3-15</u> , 19 <u>57</u> , to <u>3-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>57</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Suite 400, 8218 Wisconsin Ave.</u> DATE SIGNED <u>3/21/57</u>							
ACTUAL SIGNATURE <u>Edward S. Witowski Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>EDWARD S. WITOWSKI JR. MD. Bethesda 14, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Beaice Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03108

## CERTIFICATE OF DEATH

03088

214

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4801 CONN AVE. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE LAKE NURSING HOME</u>		d. STREET ADDRESS <u>WASHINGTON</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK PRENETTE HOOVER</u>		4. DATE OF DEATH Month Day Year <u>March 13 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 18 1895</u> 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HOOVER</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Maple Lake Nursing Home Records</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN. 27, 1957</u> , to <u>March 13, 1957</u> , that I last saw the deceased alive on <u>March 13, 1957</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>3206 Norway Dr. Washington, D.C.</u> DATE SIGNED <u>March 13, 1957</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>		<u>Cheng Chao</u> <u>md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ch. H. Dennis Co. Washington</u>		ADDRESS <u>Washington</u> 24a. REC'D BY REGISTRAR <u>MAR 15 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>	

RECEIVED



03109

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA 14</b>				c. LENGTH OF STAY IN 1b <b>24 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>				d. STREET ADDRESS <b>8515 - HOOD STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>FRANCIS</b>		First <b>J.</b> Middle <b>J.</b> Last <b>HORAN</b>		4. DATE OF DEATH <b>MARCH 21</b>		Day <b>21</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 3 - 1900</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T.</b>		11. BIRTHPLACE (State or foreign country) <b>DIST. OF COLUMBIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>TIMOTHY HORAN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN ABBIE FOLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>8515 HOOD ST. MRS. CHRISTINA I. HORAN TAKOMA PK., M.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion c Thrombosis Left Coronary Artery</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Edema c Bilateral Pleural Effusion -</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 March, 1957</b> , to <b>21 March, 1957</b> , that I last saw the deceased alive on <b>21 March, 1957</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Merton L. White</b>		M.D. <b>11134 George &amp; Ave Ashland 21 March 57</b>					
PHYSICIAN'S NAME (Type) <b>MERTON L. WHITE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>				ADDRESS <b>3821-14th NW Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-25-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

08208

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH REGISTRATION

**RECEIVED**  
MAR 26 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03035

## CERTIFICATE OF DEATH

03090

Reg. Dist. No. 2203

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> 1615.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>2203 Guilford Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Houser</u> Last <u>Houser</u>				4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-17-57</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Roger William Houser</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Earl Hullinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---			
17. INFORMANT <u>Father</u>				Address <u>2203 Guilford Road, W. Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> (Present at birth) 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>Placenta Previa</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-17</u> , 19 <u>57</u> , to <u>3-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>57</u> , and that death occurred at <u>5:19p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Chinn, M.D.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>925 Pershing Dr., Silver Spring, Md.</u> <u>3-18-57</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Chinn, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. &amp; Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>				ADDRESS <u>Wash. San. &amp; Hosp.</u>		24a. REC'D BY REGISTRAR DATE <u>3/19/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John A. Dadd</u>			

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MA

1957

BUREAU

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03110

## CERTIFICATE OF DEATH

03091

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>15 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>507 PHILADELPHIA AVE.</u>		d. STREET ADDRESS <u>507 PHILADELPHIA AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emily L Hudnut</u>		4. DATE OF DEATH Month Day Year <u>MARCH 3 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 5, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PATTERSON, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM L. ALLISON</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN LOMBARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>RUTH HUDNUT</u>		Address <u>507 SILV. SP. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>10 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1946</u> , to <u>March 3, 1957</u> , that I last saw the deceased alive on <u>March 3, 1957</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>		M.D. <u>7852</u> ADDRESS (Street, city or town, state) <u>16 44, Wash DC</u> DATE SIGNED <u>13</u>	
PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash Mem</u>		22d. LOCATION (City, town, or county) (State) <u>W. Hyattsville, Md.</u>	
23a. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamberlin Co., Riverdale, Md.</u>		23b. REC'D BY REGISTRAR <u>Francis Potter</u>	
23c. ADDRESS <u>1115 A.M.</u>		23d. DATE <u>MAR 5 1957</u>	



BUREAU V. S.

MAR 5 1955

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03092

03111

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>Since Aug. '56</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. PHILOMENA REST HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HELENE</b> Middle <b>CATHERINE</b> Last <b>HUGHES</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/10/91</b>	
9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN KERN BENTLEY</b>				14. MOTHER'S MAIDEN NAME <b>MARY ELLEN MACBURY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>YES</b>		17. INFORMANT Mrs. Walter C. Hughes, Jr., 10,613 Eastwood Ave. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Left Ovary &amp; Omentum</b> DUE TO <b>involving whole abdomen</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arterio-sclerosis</b> DUE TO <b>9 months</b> (c) <b>General Arterio-sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July</b> 19 <b>56</b> , to <b>March 21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 20</b> , 19 <b>57</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington 12 DC</b> DATE SIGNED <b>3/26/57</b>							
ACTUAL SIGNATURE <b>Wm F Greaney</b>				M.D. <b>7542 123874</b>			
PHYSICIAN'S NAME (Type) <b>WM F GREANEY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner L. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 3/26/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		Male		White		Jan 5, 1928		Memphis, Tenn.		Memphis, Tenn.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		COUNTRY OF INTERMENT	
April 4, 1968		Memphis, Tenn.		Memphis, Tenn.		U.S.A.		April 8, 1968		Graceland Cemetery		Memphis, Tenn.		U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
Gunshot wound		Suicide		Attorney		High School		Methodist		Married		Single		Married	
DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

James Earl Ray  
 Attorney  
 Gunshot wound

BUREAU V. 5

MAR 28 1968

RECEIVED

W. F. CREANEY  
 W. F. CREANEY  
 W. F. CREANEY

03112

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>7 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital, 8600 Georgetown Rd., Bethesda, Md.</b>				d. STREET ADDRESS <b>4125 Harrison Street, N.W., Washington, D. C.</b>			
3. NAME OF DECEASED (Type or print) First <b>Mark</b> Middle <b>Leslie</b> Last <b>Hull</b>				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 30, 1893</b>	
9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>13</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manufacturer's Occupation</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Montana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Turco, Mrs Angelina - Friend.</b> Address <b>(Above)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Arterio Sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b> <b>24 hr.</b> <b>10 yr.?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 20, 1950</b> to <b>13 March, 1957</b> , that I last saw the deceased alive on <b>13 March, 1957</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7936 Georgetown Rd. Bethesda - 14 Md.</b> DATE SIGNED <b>March 14/57</b>							
ACTUAL SIGNATURE <b>John G. Ball</b>				M.D. <b>John G. Ball, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>John G. Ball, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3/14/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 3-16-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bernice M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

MAR 19 1957

RECEIVED

Obert A. Humphrey - 1957 - 12 - Ave. R. H. M. D.  
Cedar Hill  
3/14/1957

John G. Hall, M. D.



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

03113

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3100 Cathedral Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Jules (nmn) JAMES		4. DATE OF DEATH Month Day Year March 12 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Feb. 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John James		14. MOTHER'S MAIDEN NAME Ann Maria Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 6-9-04 to 11-1-46		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema, Pulmonary 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10-11 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11 March, 19 57, to 12 March, 19 57, that I last saw the deceased alive on 12 March, 19 57, and that death occurred at 8:40A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-13-57			
ACTUAL SIGNATURE <i>Bruce L. Canaga</i> M.D. U.S. Naval Hospital, Bethesda, Md. 3-13-57			
PHYSICIAN'S NAME (Type) BRUCE L. CANAGA, JR. CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-14-57	22c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery	22d. LOCATION (City, town, or county) (State) Danville, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gawler's &amp; Sons</i> Gawler's & Sons, 1756 Penn Ave., N.W. Wash.D.C.		24a. REC'D BY REGISTRAR DATE 3-13-57	24b. REGISTRAR'S SIGNATURE <i>Mary E. Parrelly</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DATE OF

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF CHIEF CLERK</p>		<p>18. SIGNATURE OF ASSISTANT CLERK</p>		<p>19. SIGNATURE OF DEPUTY CLERK</p>		<p>20. SIGNATURE OF DEPUTY ASSISTANT CLERK</p>	

BUREAU V. S.

MAR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03095

03-14

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>x2 Chevy Chase</b>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>90 Resmor Sanitarium &amp; Hospital</b>				d. STREET ADDRESS <b>4847 Crescent St. W.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>J</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>19 57</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/28/1878</b>		9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Merchant</b>				11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joshua Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Veronica Wood</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Belle B. Johnson, Same as # 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>atherosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260x</b> (b) <b>Coronary heart disease &amp; advanced peripheral</b> DUE TO (c) <b>Diabetes mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 yrs</b> <b>3 yrs.</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec 1</b> , 19 <b>51</b> , to <b>3/3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/3</b> , 19 <b>57</b> , and that death occurred at <b>4:45</b> A.M., from the causes and on the date stated above.															
ACTUAL SIGNATURE <b>S. A. THOMAS, M. D.</b> PHYSICIAN'S NAME (Type) <b>4301-48TH ST. N.W.</b>				ADDRESS (Street, city or town, state) <b>WASHINGTON, D. C.</b>				DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's Sons Inc</b>				ADDRESS <b>1756 Pa. Ave., N.W.</b>				24a. REC'D BY REGISTRAR <b>DATE 3-6-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>					

BUREAU V. S.

MAR 8 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03115

## CERTIFICATE OF DEATH

03096

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>			
c. LENGTH OF STAY IN 1b <u>15 mos.</u>				d. STREET ADDRESS <u>6111 UTAH AVE. N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Livingston S. Johnson</u>				4. DATE OF DEATH <u>MAR 12 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 24 1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASSESSOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DIST. GOVT.</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>VALENTINE MASON JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA BOGGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>LIVINGSTON L. JOHNSON</u>		17. INFORMANT <u>4572 - 49TH ST. N.W. WASH. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>15 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 23, 1956</u> to <u>March 12, 1957</u> , that I last saw the deceased alive on <u>March 11, 1957</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Havell</u>				ADDRESS (Street, city or town, state) <u>5516 Neb. Ave. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>				DATE SIGNED <u>3-12-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middleburg Mem. Cmn.</u>		22d. LOCATION (City, town, or county) (State) <u>Middleburg Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home, 5103 Kingman</u>				24a. REC'D BY REGISTRAR <u>3-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

FILE NO. 10-10-10

DATE OF DEATH

1. Name of Deceased: *John Doe*  
 2. Sex: *Male*  
 3. Age: *45*  
 4. Date of Birth: *1912*  
 5. Place of Birth: *MD*  
 6. Usual Residence: *MD*  
 7. Cause of Death: *Heart Disease*  
 8. Date of Death: *1957*  
 9. Place of Death: *MD*  
 10. Signature of Physician: *[Signature]*  
 11. Signature of Registrar: *[Signature]*

BUREAU. V. S.

MAR 18 1957

RECEIVED





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
03036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03098  
Reg. Dist. No. 4/3

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. San. and Hosp.</b>				d. STREET ADDRESS <b>White Oak, Stewart Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Henry</b> Last <b>Joppy</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>col</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/14/1918</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>garbage truck</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Henry Joppy</b>				14. MOTHER'S MAIDEN NAME <b>Annie Neal</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hosp. Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/29/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/1/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park.,</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Suorden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/4/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>J. Wilson Adley</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00028

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. OCCUPATION None		5. MARITAL STATUS Single		6. PLACE OF BIRTH Jackson, Mississippi	
7. DATE OF DEATH April 4, 1968		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
10. CAUSE OF DEATH FIREARMS WOUND TO THE CHEST		11. MANNER OF DEATH Suicide		12. SIGNATURE OF EXAMINER [Signature]	
13. SIGNATURE OF WITNESS [Signature]		14. SIGNATURE OF CORONER [Signature]		15. SIGNATURE OF POLICE [Signature]	

RECEIVED  
APR 3 1968  
BUREAU V. S.



03037

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03099

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>24 hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanatarium &amp; Hosp.</b>			d. STREET ADDRESS <b>18430 Piney Branch Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Justus</b> Last <b>Justus</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>21,</b> Year <b>1957</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/93</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			13. FATHER'S NAME <b>August Justus</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown Elizabeth Rhinehart</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		
16. SOCIAL SECURITY NO. <b>578-09-5886</b>			17. INFORMANT <b>Hospital Records</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 900.0 DUE TO <b>Fracture of Skull</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>22 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell backward down steps</b>			
20c. TIME OF INJURY <b>6:30 p.m.</b>	Month, Day, Year <b>3/20/57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) (County) (State) <b>Silver Spring Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			22b. DATE THEREOF <b>3/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cemetery</b>
			22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b>			ADDRESS <b>8434 Ave</b>		24a. REC'D BY REGISTRAR <b>3/25/57</b>
			24b. REGISTRAR'S SIGNATURE <b>William D. Bell</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15083

STATE OF MARYLAND - BALTIMORE 13

15083

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1945		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
EDUCATION		SCHOOL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HIGH SCHOOL		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
OCCUPATION		BUSINESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
BUSINESS		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
RELIGION		METHODIST		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
METHODIST		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
CAUSE OF DEATH		HEART DISEASE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HEART DISEASE		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
MANNER OF DEATH		NATURAL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
NATURAL		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
SIGNATURE OF EXAMINER		JAMES EARL RAY		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
JAMES EARL RAY		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
DATE OF EXAMINATION		1968		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
1968		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
PLACE OF EXAMINATION		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES	

BUREAU V. 2

MAR 27 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03117

CERTIFICATE OF DEATH

Reg. Dist. No. *216*

03100

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Pazewell</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>108 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Box 563</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lycurgus</b> Last <b>Justus</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 31, 1878</b>		9. AGE (In years lost birth day) yrs. <b>78</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>26</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Justus</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ledgewood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EDEMA OF LUNGS</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UREMIA</b> DUE TO (c) <b>CHRONIC NEPHRITIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>3 days</b> <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MYELOID METAPLASIA</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>December 9, 1956</b> to <b>March 27, 1957</b> , that I last saw the deceased alive on <b>March 27, 1957</b> , and that death occurred at <b>9:30A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Daniel Nathans</b>				DATE SIGNED <b>3/28/57</b>			
PHYSICIAN'S NAME (Type) <b>Daniel Nathans, M. D.</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>3/28/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Richlands</b>		22d. LOCATION (City, town, or county) (State) <b>Richlands, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3-28-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

March 27, 1957

Montgomery

Alabama

100 days

March

The Clinical Center, Bethesda 10, Md.

Box 103

William

Lyons

James

White

3

October 22, 1956

Railroad Commission

Bedford

Tennessee

Robert L. Smith

Baron Lebedev

not available

The Clinical Center, Bethesda 10, Md.

BUREAU V. 2

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RECEIVED

03118

## CERTIFICATE OF DEATH

Reg. Dist. No.

031014

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9405 SEMINOLE ST.</b>		1. d. STREET ADDRESS <b>9405 SEMINOLE ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>GENEVIEVE</b> Last <b>KEEGIN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>1</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 21, 1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JOSEPH FRANCIS KEIM (KIEM)</b>	
14. MOTHER'S MAIDEN NAME <b>MARY NEIDEMEYER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Joseph Keegin</b> Address <b>Silver Spring Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>2 years</b> <b>years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Occlusion</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>— 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) (County) (State) <b>—</b>
21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>February</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb 24</b> , 19 <b>57</b> , and that death occurred at <b>1:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Olney, Md.</b> DATE SIGNED <b>3/1/57</b>			
ACTUAL SIGNATURE <b>Richard A. Yates</b>		PHYSICIAN'S NAME (Type) <b>RICHARD A. YATES</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/4/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. CLEMENS CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO - RIVERDALE, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	24b. REGISTRAR'S SIGNATURE <b>Frances Patten</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES EARL RAY		M		39		W		12-1-27		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
MEMBER OF CONGRESS		MARRIED		HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE ATTORNEY GENERAL, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

03119

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03102

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>3 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD # 3</b>				d. STREET ADDRESS <b>RFD # 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>Eunice</b> Last <b>Kelchner</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>22.</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>May 5, 1904</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph J. Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Nellie G. Huhn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Paul B. Kelchner, Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Mar. 23, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b>				ADDRESS <b>Gaithersburg. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>3/25/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Abigail G. Cooke</b>	

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG212 3-26-57 et

## CERTIFICATE OF DEATH

03103

Reg. Dist. No. 276

03120

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 16</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3 Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>3621 Newark St. N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Jones</b> Last <b>King</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/11/1879</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Hiram Jones</b>				14. MOTHER'S MAIDEN NAME <b>Anna Stewart Fahnestock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Dr. Barry Griffith King</b>				Address <b>Wash 16, DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic coronary artery Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized weakness from major pelvic surgery 4/25/57</b>				INTERVAL BETWEEN ONSET AND DEATH <b>35 Minutes</b> <b>3 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>September, 1953</b> , to <b>March 17, 1957</b> , that I last saw the deceased alive on <b>March 17, 1957</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3408 Wisconsin Ave NW</b>							
ACTUAL SIGNATURE <b>W R Storer</b> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, <del>REMOVING</del> (Specify)		22b. DATE THEREOF <b>3/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				ADDRESS <b>Wash, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-19-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>							

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX Male		AGE 35	
DATE OF DEATH April 4, 1968		TIME OF DEATH 1:00 PM		PLACE OF DEATH Memphis, Tennessee	
CAUSE OF DEATH Gunshot wound		MANNER OF DEATH Homicide		PLACE OF BIRTH Jackson, Mississippi	
OCCUPATION Minister of the Gospel		EDUCATION High School Graduate		MARITAL STATUS Single	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF JURY (None)		SIGNATURE OF DEATH CERTIFICATE (None)	

BUREAU V. 2

MAR 21 1968

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03104

03121

## CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Germantown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural no 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilma</u> Middle <u>Ray</u> Last <u>King</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 7-57</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germantown, Rural, Md.</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>William G. King</u>			
14. MOTHER'S MAIDEN NAME <u>Sylvia M. Williams</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>William G. King, Germantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>asphyxia</u> <u>761.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>prolapsed cord</u> (c) <u>Breech delivery</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>March 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>57</u> , and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vernon E. Martens</u> M.D. <u>Germantown, Md.</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Vernon E. Martens</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>				ADDRESS <u>Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Mar 8-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Abigail L. Cooke</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03105
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										212
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boys</u>			c. LENGTH OF STAY IN 1b <u>DOA.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boys</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Boys-Barnesville Rd.</u>					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard M Kitts</u>					4. DATE OF DEATH Month Day Year <u>Mar. 31, 1957 19</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/8/1939</u>		9. AGE (in years last birthday) <u>17</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Irvin Floyd Kitts</u>					14. MOTHER'S MAIDEN NAME <u>Nona Guillers</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>M.C. Police</u> Address <u>Rockville Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of Skull</u> (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian. Struck by auto.</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>2:40</u> p.m. <u>3/31/57</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) (County) (State) <u>Boys Montg. Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/31/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/2/57</u>			22b. DATE THEREOF <u>St Pauls</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Hanover Va</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton Barnesville Md</u>					24a. REC'D BY REGISTRAR DATE <u>4/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>			

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 19

BUREAU V. S.

APR 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 212 3-28-57 et

## CERTIFICATE OF DEATH

03123

03106

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Addie</b> Middle <b>Drullard</b> Last <b>Koch</b>				4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1873</b>	9. AGE (In years last birthday) <b>83 87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <b>Buffalo, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Edward Drullard</b>				14. MOTHER'S MAIDEN NAME <b>Susie McKenna</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ross McNeil</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>450.0</b> DUE TO <b>Cardiac decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1944</b> , to <b>March 15, 1957</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>6:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda, Md.</b> DATE SIGNED <b>3/16/57</b>							
ACTUAL SIGNATURE <b>W. T. Joyce, M.D.</b>				PHYSICIAN'S NAME (Type) <b>W. T. Joyce, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 3-18-57</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Erie County, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-18-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bea M. Thompson</b>			



# CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE, 18

62453

DATE OF DEATH

DECEASED

SEX

AGE

PLACE OF BIRTH

DATE OF BIRTH

EDUCATION

RELIGION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

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CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

BUREAU V. 8

MAR 21 1957

RECEIVED

8108 Maple Ridge Rd, Baltimore, Md. 21212

W. J. Joyce, M.D.

03124

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03107

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. LENGTH OF STAY IN 1b <u>Poolesville x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Kohlhoss</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Garage owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Charles Kohlhoss</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Jane Carlisle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Charles Kohlhoss - Poolesville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>20 May, 1953</u> , to <u>24 Mar 1957</u> , that I last saw the deceased alive on <u>23 March 1957</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Fawcett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3/24/57</u>	
PHYSICIAN'S NAME (Type) <u>JOHN C. FAWCETT</u>		M.D. <u>DAWSONVILLE P.O. Bayl</u> <u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u> ADDRESS <u>Barnesville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>3/26/57</u>	24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>

BUREAU V. S.

MAR 22 1957

RECEIVED

03125

CERTIFICATE OF DEATH

03108

Reg. Dist. No. 176

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>6615 Western Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Reese</u> Last <u>Larson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-76</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
13. FATHER'S NAME <u>Reese</u>		14. MOTHER'S MAIDEN NAME <u>Sara Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Calvert L. Dedrick</u>	
17. INFORMANT <u>Calvert L. Dedrick</u>		Address <u>6615 Western Ave. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Cerebral Arterio sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 16 1957</u> to <u>March 27 1957</u> , that I last saw the deceased alive on <u>March 23 1957</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Harell</u>		DATE SIGNED <u>3-27-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. Harell</u>		M.D. <u>5516 Nebraska Ave. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/27/57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Dodgville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Dodgville, Wis.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chry Chase Fund Home</u>		24a. REC'D BY REGISTRAR <u>DATE 3-28-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS CERTIFICATE OF DEATH

BUREAU V. S.

MAR 29 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

03126

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 6 Film G214 4-26-57 et  
CERTIFICATE OF DEATH

Reg. Dist. 03109/6

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>W. Va.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>27 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Washington 27, 16x22</b>			
d. STREET ADDRESS <b>1401 52nd Street, N.W., N.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Charlotte</b> Middle <b>Isabelle</b> Last <b>Lawton</b>		4. DATE OF DEATH		Month <b>March</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1904</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months <b>52</b> Days <b>12</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis A. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Ruth G. Cooke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarct left hemisphere</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>subacute inf. endocarditis</b> DUE TO (c) <b>Carotid artery of cervix</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>February 13, 1957</b> to <b>March 12, 1957</b> , that I last saw the deceased alive on <b>March 12, 1957</b> , and that death occurred at <b>12:00 Midnight</b> . ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/12/57</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>S. Weissman</b> M.D.				PHYSICIAN'S NAME (Type) <b>S. Weissman, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. McGuire</b>				ADDRESS <b>1820 9th St., N.W.</b>		24. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>	

MAR 15 1957

RECEIVED  
MAR 15 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03038

## CERTIFICATE OF DEATH

03110

Reg. Dist. No.

223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>315 Pennwood Road</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary</u>		First Middle Last <u>Caroline Layton</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>March 4 1957</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Cauc</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 13, 1875</u>									
<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.						
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
	Hours														
	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>									
						<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>Francis Turpin</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Love Hackett</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mrs. Mary L. Downer</u>		Address <u>3007 Erie St. S.E., Wash. D.C.</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x PULMONARY EDEMA -</u> DUE TO (b) <u>Hypostatic PNEUMONIA BILATERAL</u> DUE TO (c) <u>CEREBRAL HEMORRHAGE (LEFT) -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>200x</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS</u> <u>96 HRS</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS GEN. DIABETES MELLITUS. HYPERTENSION</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I attended the deceased from</b> <u>1943</u> to <u>MARCH</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MARCH</u> , 19 <u>57</u> , and that death occurred at <u>4:15</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4316-14th St NW</u> DATE SIGNED <u>3/1/57</u>															
<b>ACTUAL SIGNATURE</b> <u>Jacob Cepros</u> M.D.				<b>PHYSICIAN'S NAME (Type)</b> <u>JACOB CEPROS M.D. - WASHINGTON - D.C.</u>											
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>3/7/57</u>		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Unity-Washington Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Hurlock, Md.</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thos. A. Hiner</u>				<b>24a. REC'D BY REGISTRAR</b> <u>3/6/57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>J. H. H. H.</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 03127 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b <b>3 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,714 St. Margaret Way</b>				d. STREET ADDRESS <b>10,714 St. Margaret Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WADE</b> Middle <b>HAMPTON</b> Last <b>LEE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/27/86</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Y.M.C.A. Secretary (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Stanley County, N. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JAMES LEE</b>				14. MOTHER'S MAIDEN NAME <b>MARY HARTSELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>705-05-6690</b>		17. INFORMANT Address <b>Mrs. Myrtle L. Mayhue, 10,714 St. Margaret Way Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>None</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hr 20 min</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1956</b> to <b>3-20-1957</b> , that I last saw the deceased alive on <b>3-20-1957</b> , and that death occurred at <b>12:05</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John S. Rogers</b> M.D.				DATE SIGNED <b>3-20-57</b>			
PHYSICIAN'S NAME (Type) <b>JOHN S. ROGERS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MILGROVE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MIDLAND, NORTH CAROLINA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>3/26/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Francis Potter</b>			



**BUREAU V. S.**

MAR 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
03128  
CERTIFICATE OF DEATH

03112

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Alabama</u> b. COUNTY <u>Stevenson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>40X-3</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Alston LEGG</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 Feb. 1901</u>		9. AGE (In years lost birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>William LEGG</u>			
14. MOTHER'S MAIDEN NAME <u>Katherine ALSTON</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes. 6-5-24 to 10-1-54</u>			
16. SOCIAL SECURITY NO. <u>418-50-4892</u>				17. INFORMANT <u>Official Navy Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperextension Cardiovascular Disease, malignant</u> DUE TO <u>441X</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>male</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>20 March</u> , 19 <u>57</u> , to <u>25 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 March</u> , 19 <u>57</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bruce L. Canaga</u> M.D.				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>3-26-57</u>			
PHYSICIAN'S NAME (Type) <u>BRUCE L. CANAGA, JR. CAPT, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Humphrey</u> ADDRESS <u>1557 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>Mary E. Parrelly</u> 24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u> DATE <u>3-26-57</u>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH REGISTRY

FILE NO. 100-100000

DATE OF DEATH: 10-10-1957

PLACE OF DEATH: 100-100000

DATE OF BIRTH: 10-10-1957

PLACE OF BIRTH: 100-100000

DATE OF DEATH: 10-10-1957

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DATE OF DEATH: 10-10-1957

PLACE OF DEATH: 100-100000

BUREAU V. R.

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03113

03129

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8110 Tahona Dr.</b>		d. STREET ADDRESS <b>8110 Tahona Dr.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dr. Fritz</b> Middle <b>Levy</b> Last <b>Levy</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/18/87</b>
9. AGE (In years last birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months <b>50</b> Days <b>20</b> Hours <b>20</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Germany</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Dr. William Levy</b>		14. MOTHER'S MAIDEN NAME <b>Anna Frankel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Albert G. D. Levy, 1518 Flora Court, Sil. Spg., Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure; myocarditis - arterial disease</b> 422.1 DUE TO <b>several years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Kyphoscoliosis (osteoporotic) &amp; emphysema</b> 50 yrs. DUE TO (c) <b>Stenosis, hypocalcemia</b> 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>pothoma hepatitis &amp; recent trial intubation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 9</b> , 19 <b>57</b> , to <b>May 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Mar 9</b> , 19 <b>57</b> , and that death occurred at <b>8 a. m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. J. Stieglitz</b>		DATE SIGNED <b>MAR 11 1957</b>	
PHYSICIAN'S NAME (Type) <b>E. J. STIEGLITZ, M.D.</b>		ADDRESS (Street, city or town, state) <b>1726 EYE ST., N.W. WASHINGTON 6, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons, 3501 14th St., N. W.</b>		24a. REC'D BY REGISTRAR <b>3/13/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Francis Peltz</b>			





03130

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>XXXXX Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Cabin John</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Butler and River Road</u>				d. STREET ADDRESS <u>1 Wilson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Leyking</u> Last <u>XXXXX</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1908</u>		9. AGE (In years last birthday) <u>48 yrs.</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machanic plumbing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Victor XXXXX Leyking</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kuffner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(wife) Same as Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last, DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural forces <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/11/57</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>3-14-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director. OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BOKEAD

MAR 18 1964

RECEIVED

MAR 18 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03131

## CERTIFICATE OF DEATH

031154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		d. STREET ADDRESS <u>1820 Thayer Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>820 Thayer Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hilda</u> First <u>Gross</u> Middle <u>Lockett</u> Last		4. DATE OF DEATH <u>March</u> Month <u>7</u> Day <u>1957</u> Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1901</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - OWN HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Richard Gross</u>		14. MOTHER'S MAIDEN NAME <u>Mary Goette</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-07-3578</u>	
17. INFORMANT <u>Carrie Ashworth</u> Address <u>820 Thayer Ave, S. Spg. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary with Metastases</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>175X</u> DUE TO (c) <u>175X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>175X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 19 <u>56</u> , to <u>March 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>57</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>3-7-57</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock, M.D. Takoma Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>3/13/57</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 3

MAR 19 1957

RECEIVED

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03132

## CERTIFICATE OF DEATH

Reg. Dist. No.

03116  
216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 10 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL			d. STREET ADDRESS 11012 WOODSIDE PARKWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle HENRY Last LOHR			4. DATE OF DEATH Month MARCH Day 13 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7, 1869		9. AGE (In years last birthday) yrs. 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT - RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MADISON, VIRGINIA	
13. FATHER'S NAME HENRY LOHR			14. MOTHER'S MAIDEN NAME MILDRED TUCKER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-26-1443		17. INFORMANT Address Mr. Henry W. Lohr, 3427 Tulane Drive W. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Rt. middle & lower lobe pneumonia - embolism (b) Similarity and debility - aspiration (c) DUE TO Aspiration of ingested materials PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral hydropneumothorax & generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from November 13, 1956, to March 13, 1957, that I last saw the deceased alive on March 13, 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE JASON GEIGER			DATE SIGNED 3/14/57		
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) BURIAL			22b. DATE THEREOF 3/16/57		22c. NAME OF CEMETERY OR CREMATORY GRAHAM CEMETERY
22d. LOCATION (City, town, or county) ORANGE, VIRGINIA			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey			24a. REC'D BY REGISTRAR DATE 8-16-57		
24b. REGISTRAR'S SIGNATURE Bernie M. Thompson			ADDRESS SILVER SPRING, MD.		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03039

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 Film 212 3-28-57 et

CERTIFICATE OF DEATH

03117

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>PRINCE GEORGES Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16152 Hyattsville (Langle y Park)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sant Hosp.</u>				d. STREET ADDRESS <u>8307 - 11th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Joseph</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18 1928</u>	
9. AGE (In years last birthday) <u>29</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash. DC.</u>	
13. FATHER'S NAME <u>Owen Long</u>				14. MOTHER'S MAIDEN NAME <u>Susan Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II Navy</u>				16. SOCIAL SECURITY NO. <u>579-30-3151</u>			
17. INFORMANT <u>Mrs. Helga Long</u>				Address <u>Same.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>@ 3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 24</u> , 19 <u>57</u> , and that death occurred at <u>945 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard A Fitzgerald</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>217 University Blvd E</u> <u>3-24-57</u>			
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				<u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>MAR 26 1957 Wheaton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon, F. D., 3831 Georgia Ave., N.W.</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <u>James Lewis</u>			



03133

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>3 mos. 20 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria 83x-3</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1619 Mount Eagle Place</b>			
3. NAME OF DECEASED (Type or print) First <b>Miriam</b> Middle <b>Eastburn</b> Last <b>LOVELESS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 March 1904</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>William K. Eastburn</b>			
14. MOTHER'S MAIDEN NAME <b>Miriam Kirkland</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Husband, Francis J. Loveless (Same As #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ependymoma, Spinal Cord</b> <b>193x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>27 Nov.</b> , 19 <b>56</b> , to <b>16 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>15 March</b> , 19 <b>57</b> , and that death occurred at <b>1:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>R.W. Mackie MD</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b> <b>3-16-57</b> PHYSICIAN'S NAME (Type) <b>R.W. MACKIE, CDR, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Collins</b>				ADDRESS <b>3821 14th St., N.W., Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>3-16-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Casarely</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.



03134

CERTIFICATE OF DEATH

03119

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban-6600-old Geo. town Rd.</u>				d. STREET ADDRESS <u>4705-Hunt Ave Ch. Ch.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HALLIE ETHEL Lyles</u>				4. DATE OF DEATH Month Day Year <u>March 14 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1981-10-1-5</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George W. Lyles</u>				14. MOTHER'S MAIDEN NAME <u>Mary Eliza Dyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT Address <u>MRS Bessie Pierce (sister)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-Intestinal Hemorrhage</u> <u>541.0</u> DUE TO <u>Bleeding Ulcer, Duodenal Bulb.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis, Uremia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/13/57</u> , 19 <u>57</u> , to <u>3/14/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/13/57</u> , 19 <u>57</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Witowski Jr. MD.</u>				ADDRESS (Street, city or town, state) <u>Suite 400, 8218 Wisconsin Ave.</u>			
DATE SIGNED <u>3-16-57</u>							
PHYSICIAN'S NAME (Type) <u>EDWARD S. WITOWSKI JR. MD. BETHESDA 14, MARYLAND.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA		MOBILE		UNITED STATES OF AMERICA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES OF AMERICA		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES OF AMERICA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SOURCES OF INFORMATION	
FIREARM WOUND TO THE CHEST		SUICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		ONE		FAMILY AND MEDICAL RECORDS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

MAR 19 1967

3/19/67 Box Creek

County A. Humphrey-Bethesda, Md.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

214

03135

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1815 MALCOLM DR</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>J.</u> Last <u>MCCARTHY</u>				4. DATE OF DEATH Month <u>MAR.</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 6, 1956</u>	
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASH DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN J. MCCARTHY</u>				14. MOTHER'S MAIDEN NAME <u>MARIE E. RUGGIERO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>FATHER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-enteritis, Acute</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>MARCH</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MARCH 11</u> , 19 <u>57</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.				ADDRESS (Street, city or town, state) <u>9620 Old Bladenburg Rd Silver Spring, Md.</u>			
DATE SIGNED <u>3-12-57</u>							
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Tatternell</u> ADDRESS <u>3619-14th St.</u>				24a. REC'D BY REGISTRAR <u>MAR 14 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

9VVVVVVVVVV

BUREAU U. S.

MAR 14 1957

RECEIVED  
MAR 14 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

03136

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03121

Reg. Dist. No.

219

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Md. R-97 nr. Sunshine DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1432 Perry Place N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> T. Middle <b>McGann</b> Last		4. DATE OF DEATH Month <b>Mar.</b> Day <b>16</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/3/1918</b>
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>usa</b>	
13. FATHER'S NAME <b>Thomas Joseph</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Rombach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Montg Co. Police</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoracic and Abdominal hemorrhage</b> <b>823X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Crushed chest &amp; Multiple ruptures of liver</b> (c) <b>Crushed chest &amp; Multiple ruptures of liver</b> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car which left highway &amp; ran into tree</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>1:57 xx 3/16 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>White</b> <input type="checkbox"/> <b>Not white</b> <input checked="" type="checkbox"/> <b>Md R- 97</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Sunshine</b>		20f. (City or town) (County) (State) <b>Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>3/16/57</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Macphelia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Weston, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		24a. REC'D BY REGISTRAR <b>MAR 20 1957</b>	
ADDRESS <b>3821 14th. St. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Gertrude Lawler</b>	



STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: **John J. McConna**  
 SEX: **Male**  
 AGE: **32**  
 DATE OF DEATH: **Mar. 10, 1957**  
 PLACE OF DEATH: **1433 Perry Place, W.**  
 CITY: **Washington**  
 COUNTY: **D.C.**  
 OCCASION OF DEATH: **Heart Co. Police**  
 CAUSE OF DEATH: **Cerebral aneurysm & multiple fractures of liver**  
 MANNER OF DEATH: **Accident**  
 SIGNATURE OF EXAMINER: **Thomas J. McConna**  
 SIGNATURE OF WITNESS: **John J. McConna**  
 SIGNATURE OF CORONER: **John J. McConna**  
 SIGNATURE OF JURY: **John J. McConna**

BUREAU A. 2

MAR 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03122

03137

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> 02 X 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>107 Allen Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>Stewart</u> Last <u>MC LEOD</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 March 1918</u>
9. AGE (In years lost birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frederick Mc LEOD</u>		14. MOTHER'S MAIDEN NAME <u>Florence MAC LEOD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 6-2-41 to 9-1-56</u>		16. SOCIAL SECURITY NO. <u>086-16-9750</u>	
17. INFORMANT <u>Wife, Mrs. Hazel D. Mc Leod, (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 Jan.</u> , 19 <u>57</u> , to <u>24 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 March</u> , 19 <u>57</u> , and that death occurred at <u>12:30P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>R.G. Williams</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> 3-25-57	
PHYSICIAN'S NAME (Type) <u>R.G. WILLIAMS, CDR, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>755 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-25-57</u> 24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>	

MAR 26 1957

BUREAU V. S.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral cremation, or removal.

VS. A15ME(5)  
5M 9/55

03138 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										03123 2/17	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>										2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12,721 HOLDRIDGE ROAD</b>						d. STREET ADDRESS <b>12,721 HOLDRIDGE ROAD</b>					
3. NAME OF DECEASED (Type or print) First <b>IRA</b> Middle <b>FRED</b> Last <b>McMILLAN</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>14</b> Year <b>1957</b>								
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 8, 1899</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor - Mail Room</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Dept. U.S. Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ira Cooper McMillan</b>						14. MOTHER'S MAIDEN NAME <b>Mary Louise Zypphrecht</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WW # 1</b>		17. INFORMANT <b>Mrs. Robert J. Kilby, 20 W. Custis Ave. Alexandria, Virginia</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>sudden</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			3/15/57		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>3/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>						ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>3/19/57</b>		24b. REGISTRAR'S SIGNATURE <b>Francis Teller</b>	

RECEIVED



## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1957

Page No. 10

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]	
6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. EDUCATION [REDACTED]		9. RELIGION [REDACTED]		10. RACE [REDACTED]	
11. CAUSE OF DEATH [REDACTED]		12. MANNER OF DEATH [REDACTED]		13. PLACE OF DEATH [REDACTED]		14. DATE OF DEATH [REDACTED]		15. TIME OF DEATH [REDACTED]	
16. SIGNATURE OF PHYSICIAN [REDACTED]		17. SIGNATURE OF REGISTRAR [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]		19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF NEXT OF KIN [REDACTED]	

BUREAU V. 3

APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/55

Item 1 FilmG213 4-3-57 et  
03040  
BALTIMORE, 18  
CERTIFICATE OF DEATH

03125

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falcona Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cherry Chase, 15,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) (Private OR INSTITUTION) <b>7711 Garland Ave (home)</b>		d. STREET ADDRESS <b>16905 East Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Fredricka Dorothea Meininger</b>		4. DATE OF DEATH <b>March 24 1957</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Rosendale</b>		14. MOTHER'S MAIDEN NAME <b>Dorothea Sellner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>John Meininger</b> Address <b>As Above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, Generalized</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 4, 1956</b> , to <b>March 24, 1957</b> that I last saw the deceased alive on <b>March 24, 1957</b> , and that death occurred at <b>3:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James M. Whitlock</b> M.D.		ADDRESS (Street, city or town, state) <b>7701 Carroll Ave Takoma Park, Md.</b>	
DATE SIGNED <b>3-24-57</b>			
PHYSICIAN'S NAME (Type) <b>James M. Whitlock</b>			
22a. BURIAL, CREMATION, or REMOVAL <b>3/26/57</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>		ADDRESS <b>Wash, DC</b>	
24a. REC'D BY REGISTRAR <b>3/26/57</b>		DATE <b>3/26/57</b>	
24b. REGISTRAR'S SIGNATURE <b>William Dadd</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
CERTIFICATE OF DEATH

NAME OF DECEASED: *James H. Whitlock*  
DATE OF DEATH: *March 27, 1957*  
PLACE OF DEATH: *Home*  
AGE: *68*  
SEX: *Male*  
RACE: *White*  
OCCUPATION: *Retired*  
CAUSE OF DEATH: *Heart Disease*  
MANNER OF DEATH: *Natural*  
SIGNATURE OF PHYSICIAN: *[Signature]*  
DATE: *March 27, 1957*

BUREAU V. S.

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03126

03140

## CERTIFICATE OF DEATH

Reg. Dist. No. XXX 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>W.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 27, 16x22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>				d. STREET ADDRESS <u>6307 Foot Street, N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Blaine</u> Last <u>Miller, Sr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Sept. 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Miller</u>				14. MOTHER'S MAIDEN NAME <u>Sara Duvan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Sp. American War Unknown</u>		17. INFORMANT Address <u>(son) Howard B. Miller, Jr. (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of liver</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Probably 2° to carcinoma of lung (had lower left lung resection 2 yrs ago for carcinoma)</u> DUE TO (c) <u>163X</u> INTERVAL BETWEEN ONSET AND DEATH <u>2+ yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 7.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 March</u> , 19 <u>57</u> , to <u>11 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11 March</u> , 19 <u>57</u> , and that death occurred at <u>11:25 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Wm B Ingram</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 3-11-57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>WM. B. INGRAM, CDR, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat; Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAMBERS, 517 11th St., S.E. Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>DATE 3-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Frank E. Russell</u>	



MAR 15 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03141

## CERTIFICATE OF DEATH

Reg. Dist. No.

031274

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>3 or 4 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARILEA NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>DAVIS</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 9, 1877</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER (owner) retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Montgomery County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEWIS YOST MILLER</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE ELIZABETH LINDSEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Walter Y. Miller, R. #2, Columbia Pike Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Infarction</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease - about 5 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 11, 1952</b> to <b>March 24, 1957</b> , that I last saw the deceased alive on <b>March 24, 1957</b> , and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John S. Rogers</b> M.D.		DATE SIGNED <b>3-25-57</b>	
PHYSICIAN'S NAME (Type) <b>JOHN S. ROGERS</b>		ADDRESS (Street, city or town, state) <b>Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>COLESVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>3/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>James Potter</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 29 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03142

## CERTIFICATE OF DEATH

Reg. Dist. No.

03128

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>16 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4633 River Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>A</b> Last <b>Mohagen</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/27/1905</b>	
9. AGE (In years last birthday) <b>51 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Histopathologic Tech. Dept. of Agr.</b>		11. BIRTHPLACE (State or foreign country) <b>Grafton, N. Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christian Mohagen</b>				14. MOTHER'S MAIDEN NAME <b>Elise Wanlof</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Verna C. Mohagen, 4633 River Rd. Beth.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>148X</b> <b>Uremia</b> DUE TO (b) <b>wide spread metastasis of</b> DUE TO (c) <b>Carcinoma, throat</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 1/2 year</b> <b>1 1/2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>2/28</b> , 19 <b>57</b> , to <b>3/1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/1</b> , 19 <b>57</b> , and that death occurred at <b>11:30</b> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles J. Savarese, Jr.</b>				ADDRESS (Street, city or town, state) <b>4861 Battery Lane Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Charles J. Savarese, Jr.</b>				DATE SIGNED <b>3-2-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		22b. DATE THEREOF <b>3-5-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grafton Lutheran Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Walsh County, No. Dakota.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey,</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>Bea M. Thompson</b>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00143

See Rev. 10

DEPARTMENT OF HEALTH BALTIMORE		COUNTY OF BALTIMORE CITY OF BALTIMORE	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESSES [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CLERK [Illegible]	

BUREAU V. 2

MAR 5 1951

RECEIVED



03143

CERTIFICATE OF DEATH

03129

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Daytona Beach</b> <b>48X-3</b>			
d. STREET ADDRESS <b>312 Sears Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Myrl</b> Last <b>Monahan</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1896</b>	
9. AGE (In years lost birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Glover L. Gough</b>				14. MOTHER'S MAIDEN NAME <b>Nannie K. Bowling</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>577-01-4091</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neuronal shock 200 Volts 2 hrs</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the heart</b> DUE TO <b>23 mts</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 18</b> , 19 <b>57</b> , to <b>March 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 25</b> , 19 <b>57</b> , and that death occurred at <b>6:05 p. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David G. Nathan</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
DATE SIGNED <b>3/25/57</b>							
PHYSICIAN'S NAME (Type) <b>David G. Nathan, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>3/29/57</b>		<b>Belview</b>		<b>Daytona Beach, Fla</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b> ADDRESS <b>Wash, D.C.</b>				24. REC'D BY REGISTRAR <b>MAR 27 1957</b> DATE			
25. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 27 1957

BUREAU V. S.

03144

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York City 69x-3</b>		
c. LENGTH OF STAY IN 1b <b>467 days</b>			d. STREET ADDRESS <b>1250 - 1st Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Miss Helen</b>		First	Middle	Last	4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 9, 1882</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>23</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Daniel Montgomery</b>		14. MOTHER'S MAIDEN NAME <b>Ellen McArdle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA BREAST WITH METASTASES</b> <b>2 1/2 YRS</b> DUE TO (c) <b>DIVERTICULITIS OF COLON</b> <b>2 1/2 + YRS</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SURGICAL HYPOPHYSECTOMY</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>November 21, 1955</b> , to <b>March 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 2</b> , 19 <b>57</b> , and that death occurred at <b>6:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>3/3/57</b>					
ACTUAL SIGNATURE <b>Samuel Charache</b>			PHYSICIAN'S NAME (Type) <b>Samuel Charache, M. D.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Trans.</b>		22b. DATE THEREOF <b>3/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>			24a. REC'D BY REGISTRAR <b>DATE 3-5-57</b>		
24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAR 7 1957

RECEIVED

The Clinical Center  
National Institutes  
Bethesda, Md.

General Services, D. C.

November 21 1956

27

March 2

Not available. The Clinical Center, Bethesda, Md.

The Medical Record  
Eliza Howells

Medical Montgomery

Montgomery

Montgomery

Practical Nurse

White

Female

Toronto

Illian

Montgomery

March 2

September 9, 1952

1950 - 1st Avenue

The Clinical Center, Bethesda, Md.

1st Ave

Bethesda, Md.

New York City

New York

Montgomery

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 03145 CERTIFICATE OF DEATH

03131

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Timothy</b> Last <b>MULCAHY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 March 1957</b>		9. AGE (In years lost birthday) yrs. <b>4</b>		IF UNDER 1 YEAR Months <b>4</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John J. MULCAHY</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
14. MOTHER'S MAIDEN NAME <b>Josephine Marie Pugh</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT Address <b>(Father) John J. MULCAHY (Same As #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Erythroblastosis fetalis</b> <b>770.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>70 hrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>9.</b> p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>20 March</b> , 19 <b>57</b> , to <b>24 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>24 March</b> , 19 <b>57</b> , and that death occurred at <b>10:35 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Daniel Shuptar</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Daniel Shuptar</b>				DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>3-25-57</b>			
				24b. REGISTRAR'S SIGNATURE <b>Barry E. Parselley</b>			

2051264XV4



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

MAR 26 1957

RECEIVED

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	

03146

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 mos. 19 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>O'Hagan</u> Last <u>O'Hagan</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 15, 1864</u>	
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>57</u>		IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Patrick O'Hagan</u>				14. MOTHER'S MAIDEN NAME <u>Alice Stuart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Wilbert Mc Inerney</u> Address <u>Rt. 3, Gaithersburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>150X</u> DUE TO <u>Arteriosclerosis &amp; Coronary Thrombosis associated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>&amp; Cancer of the Esophagus; &amp; metastases</u> (c) <u>&amp; Cancer of the Esophagus; &amp; metastases</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Jan 10 &amp; March 11 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>October</u> , 19 <u>57</u> , to <u>March 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-10-</u> , 19 <u>57</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Richard J. Meyer</u> M.D.				<u>1835 EYE ST. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD J. MEYER</u>				<u>WASH 6, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Barlow</u>				ADDRESS <u>1756 Penna Row NW</u>		24a. REC'D BY REGISTRAR <u>3-14-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

BUREAU V. S.

MAR 18 1957

RECEIVED

12:12V

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Muriel</b> Last <b>Oliver</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 25, 1904</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary-CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CIBA DRUG CO. Unascertainable</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>James H. Hyer</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Cooney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple thrombocytopenic hemorrhages + pancytopenia</b> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>phosphorous 32 intoxication</b> DUE TO (c) <b>metastatic breast cancer</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>4 weeks</b> <b>3 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 26, 1957</b> to <b>March 31, 1957</b> that I last saw the deceased alive on <b>March 31, 1957</b> and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b> DATE SIGNED <b>William J. Pieper</b>							
ACTUAL SIGNATURE <b>William J. Pieper</b> M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>TRANS. &amp; BURIAL</b>		<b>4/3/57</b>		<b>ST. RAYMOND CEMETERY</b>		<b>NEW YORK CITY, NEW YORK</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>4-8-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH: 1937  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
BIRTH: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
MARRIAGE: [illegible]  
RELIGION: [illegible]  
SIGNED: [illegible]  
WITNESSED: [illegible]

BUREAU V. S.

APR 5 1937

RECEIVED



03041

## CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville X0</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>(NMN)</b> Last <b>Olsen</b>			4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-81</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Norway</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Ole Olsen</b>				14. MOTHER'S MAIDEN NAME <b>Karen Mortensen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac Myocardial Infarction</b> <b>430.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260X</b> (b) <b>Coronary Atherosclerosis &amp; Hypertension</b> DUE TO (c) <b>American diet + aging</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5-10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Isabel Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1953</b> , to <b>3/26/1957</b> , that I last saw the deceased alive on <b>3/26/1957</b> , and that death occurred at <b>3:55</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John H. Wolohin</b>			M.D. <b>7401 BL &amp; IR</b>		DATE SIGNED <b>3/26/57</b>		
PHYSICIAN'S NAME (Type) <b>Cross - H. Wolohin</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit</b>		22b. DATE THEREOF <b>3/30/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Chicago Illinois</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>				ADDRESS <b>7557 Wisc. ave. Bk.</b>		24a. REC'D BY REGISTRAR DATE <b>3/27/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. Wilson Redd</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>45 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase 15</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>4911 Dorset Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>John</b> Last <b>O'Neile</b>				4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 13, 1884</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>13</b> Hours <b>13</b> Min.		IF UNDER 24 HRS. Months <b>72</b> Days <b>13</b> Hours <b>13</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bu. Ingrav. &amp; Print.</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John E. O'Neile</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Louise B. O'Neile</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiovascular disease</b> DUE TO (c) <b>112 AR</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>same as 2</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 1945</b> to <b>Mar 23, 1957</b> , that I last saw the deceased alive on <b>Feb 21, 1957</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. E. Quayle</b> M.D.				ADDRESS (Street, city or town, state) <b>1823 Baltimore St NW Washington DC</b>			
DATE SIGNED <b>Mar 26 1957</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b>				ADDRESS <b>Wash, D.C.</b>		24a. REC'D BY REGISTRAR <b>26 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

100-100000-100000

BUREAU V. 3

MAR 26 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03136

03149

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN IB <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS <b>11 Chestnut Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sharon</b> Middle <b>Lee</b> Last <b>Pearson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/57</b>		9. AGE (In years last birthday) yrs. <b>4</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Amos Landers Pearson</b>				14. MOTHER'S MAIDEN NAME <b>Frances Marie Sheeler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Record</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>7625</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> (c) <b>Prematurity</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 10, 1957</b> , to <b>March 13 1957</b> that I last saw the deceased alive on <b>March 13, 1957</b> , and that death occurred at <b>12:50AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Luciano R. Leal</b> M.D.				ADDRESS (Street, city or town, state) <b>108 N. Frederick Ave.</b> DATE SIGNED <b>3/14/57</b>			
PHYSICIAN'S NAME (Type) <b>L. I. Leal, M. D.</b>				<b>Gaithersburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-15-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg, Md.</b>				24a. REC'D BY REGISTRAR <b>3-15-57</b>		24b. REGISTRAR'S SIGNATURE <b>Gertrude B Lawley</b>	

2073171XV3



CERTIFICATE OF DEATH

1. NAME OF DECEASED Diney		2. SEX Male		3. AGE 4 days		4. DATE OF BIRTH 11/10/52		5. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
6. NAME OF DECEASED Diney		7. SEX Male		8. AGE 4 days		9. DATE OF BIRTH 11/10/52		10. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
11. NAME OF DECEASED Diney		12. SEX Male		13. AGE 4 days		14. DATE OF BIRTH 11/10/52		15. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
16. NAME OF DECEASED Diney		17. SEX Male		18. AGE 4 days		19. DATE OF BIRTH 11/10/52		20. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
21. NAME OF DECEASED Diney		22. SEX Male		23. AGE 4 days		24. DATE OF BIRTH 11/10/52		25. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
26. NAME OF DECEASED Diney		27. SEX Male		28. AGE 4 days		29. DATE OF BIRTH 11/10/52		30. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
31. NAME OF DECEASED Diney		32. SEX Male		33. AGE 4 days		34. DATE OF BIRTH 11/10/52		35. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
36. NAME OF DECEASED Diney		37. SEX Male		38. AGE 4 days		39. DATE OF BIRTH 11/10/52		40. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
41. NAME OF DECEASED Diney		42. SEX Male		43. AGE 4 days		44. DATE OF BIRTH 11/10/52		45. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
46. NAME OF DECEASED Diney		47. SEX Male		48. AGE 4 days		49. DATE OF BIRTH 11/10/52		50. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
51. NAME OF DECEASED Diney		52. SEX Male		53. AGE 4 days		54. DATE OF BIRTH 11/10/52		55. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
56. NAME OF DECEASED Diney		57. SEX Male		58. AGE 4 days		59. DATE OF BIRTH 11/10/52		60. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
61. NAME OF DECEASED Diney		62. SEX Male		63. AGE 4 days		64. DATE OF BIRTH 11/10/52		65. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
66. NAME OF DECEASED Diney		67. SEX Male		68. AGE 4 days		69. DATE OF BIRTH 11/10/52		70. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
71. NAME OF DECEASED Diney		72. SEX Male		73. AGE 4 days		74. DATE OF BIRTH 11/10/52		75. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
76. NAME OF DECEASED Diney		77. SEX Male		78. AGE 4 days		79. DATE OF BIRTH 11/10/52		80. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
81. NAME OF DECEASED Diney		82. SEX Male		83. AGE 4 days		84. DATE OF BIRTH 11/10/52		85. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
86. NAME OF DECEASED Diney		87. SEX Male		88. AGE 4 days		89. DATE OF BIRTH 11/10/52		90. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
91. NAME OF DECEASED Diney		92. SEX Male		93. AGE 4 days		94. DATE OF BIRTH 11/10/52		95. PLACE OF BIRTH Montgomery County General Hospital, Inc.	
96. NAME OF DECEASED Diney		97. SEX Male		98. AGE 4 days		99. DATE OF BIRTH 11/10/52		100. PLACE OF BIRTH Montgomery County General Hospital, Inc.	

BUREAU V. 2

MAR 21 1957

RECEIVED

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 03150  
 CERTIFICATE OF DEATH

03137

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>10 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Erwin</u> Middle <u>Lee</u> Last <u>Phelps</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>+Blacksmith</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Lewis Phelps</u>			
14. MOTHER'S MAIDEN NAME <u>Rose Nichols</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobes pneumonia RLL.</u> <u>490x</u> DUE TO <u>with abscess of pleura</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/10</u> , 19 <u>57</u> , to <u>3/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/10</u> , 19 <u>57</u> , and that death occurred at <u>1:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>[Signature]</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 13</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Unity Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boyd W. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-13-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CITY OF DEATH [Illegible]		COUNTY OF DEATH [Illegible]		STATE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

BUREAU V. S.

MAR 21 1957

RECEIVED

03042

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD. Takoma Park</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Alice</u> Last <u>Piel</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-24-85</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penns.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Michael Martz</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Kerr.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic poisoning</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstruction of ureters - bilat.</u> DUE TO (c) <u>Carcinoma of Ovary - recurrent</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>6 mo</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan. 15, 1957</u> to <u>March 10, 1957</u> , that I last saw the deceased alive on <u>March 9, 1957</u> , and that death occurred at <u>12:29 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Carroll Ave - Mar. 11 - '57</u> DATE SIGNED ACTUAL SIGNATURE <u>John F. Brownberger M.D.</u> PHYSICIAN'S NAME (Type) <u>John F. Brownberger Takoma Park - Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Vetter</u>				ADDRESS <u>254 Carroll St - S.E.</u>		24a. REC'D BY REGISTRAR <u>John Vetter</u>	
24b. REGISTRAR'S SIGNATURE <u>John Vetter</u>				DATE <u>3/13/57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint handwriting.

BUREAU V. S.

MAR 15 1957

RECEIVED

Handwritten signature and date: 10-11-57



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

03043

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03139  
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>5 min.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sligo- 7th Day Adventist Church</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A</b> Last <b>Pierson</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>16,</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 22, 1875</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Mass.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Not Available</b>				14. MOTHER'S MAIDEN NAME <b>Not Available</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>				16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mrs. Munson Cook, Ogdenburg, New Jersey</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>			
20c. TIME OF INJURY Month, Day, Year Hour <b></b> a. m. <b></b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>				20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>MAR 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HARDISON CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>NORTH CHURCH, NEW BRUNSWICK</b>				22e. (State) <b>NJ</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters, 254 Carroll St NW DC</b>				ADDRESS <b></b>		24. REC'D BY REGISTRAR <b></b>	
24. REC'D BY REGISTRAR <b></b>				24. REC'D BY REGISTRAR <b></b>		24. REGISTRAR'S SIGNATURE <b></b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
MONTGOMERY		Male		35		1918		New York		Boston		Heart Disease		Natural	
Name of Physician		Name of Hospital		Name of Doctor		Name of Nurse		Name of Attendant		Name of Undertaker		Name of Burial Place		Name of Cemetery	
J. H. Smith		St. Mary's		Dr. J. H. Smith		Miss J. H. Smith		Mr. J. H. Smith		Mr. J. H. Smith		St. Mary's		St. Mary's	
Signature of Physician		Signature of Hospital		Signature of Doctor		Signature of Nurse		Signature of Attendant		Signature of Undertaker		Signature of Burial Place		Signature of Cemetery	
J. H. Smith		St. Mary's		Dr. J. H. Smith		Miss J. H. Smith		Mr. J. H. Smith		Mr. J. H. Smith		St. Mary's		St. Mary's	

BUREAU V. S.

MAR 19 1957

RECEIVED

MAR 22 1957 HARRISON/RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

03140  
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>TUCKER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8207 GEORGIA AVENUE</b>				e. STREET ADDRESS <b>85x-3 PARSONS</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Maude Alice Plum</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>21</b> Year <b>19 57</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/4/77</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL SHAFFER</b>				14. MOTHER'S MAIDEN NAME <b>ANGELINE (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. J. Willard Plum, 8207 Georgia Ave.</b>			
				Address <b>Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure - Congestive</b>  <b>420.0</b>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            (b) <b>Arteriosclerotic Heart Disease</b>            DUE TO <b>&amp; Hypertension</b>            (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>Sym.</b></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  <b>Chronic Glomerulonephritis</b></p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November, 1954</b> , to <b>21 March 1957</b> , that I last saw the deceased alive on <b>20 March 1957</b> , and that death occurred at <b>7:50AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Russell B. Arnold</b> M.D.				ADDRESS (Street, city or town, state) <b>8801 Colesville Road</b>			
PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D.</b>				DATE SIGNED <b>Silver Spring, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CITY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PARSONS, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner B. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>3/26/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 03152 CERTIFICATE OF DEATH

031418  
218

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XIGERMANTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <div style="text-align: right;">           e. IS RESIDENCE ON A FARM?            YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>GORDON MAURICE PLUMMER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 4 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 MAY 1941</u>	
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>GARNETT AUGUSTUS PLUMMER</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH ELEANOR HOES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FATHER</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OSTEOGENIC SARCOMA, GENERALIZED METASTASIS</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OSTEOGENIC SARCOMA, PRIMARY RIGHT FEMUR</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>20 months</u> <u>20 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 1956, to <u>MARCH</u> , 1957, that I last saw the deceased alive on <u>1 MARCH</u> , 1957, and that death occurred at <u>10:20 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert M. Dimmette</u> M.D.				<u>9710 Brixton Lane, Bethesda, Md.</u> <u>4 MAR 1957</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT M. DIMMETTE M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>Cloppers, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Alicia Cook</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED MRS. J. M. [illegible]		AGE [illegible]		SEX F		RACE W		DATE OF BIRTH [illegible]		PLACE OF BIRTH [illegible]	
MARRIED TO [illegible]		OCCUPATION [illegible]		EDUCATION [illegible]		RELIGION [illegible]		MANNER OF DEATH [illegible]		CAUSE OF DEATH [illegible]	
DATE OF DEATH [illegible]		PLACE OF DEATH [illegible]		CITY [illegible]		COUNTY [illegible]		STATE MD		ZIP CODE [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF CORONER [illegible]		SIGNATURE OF DECEASED [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF DECEASED [illegible]		SIGNATURE OF WITNESS [illegible]	
DATE OF SIGNATURE [illegible]		DATE OF SIGNATURE [illegible]		DATE OF SIGNATURE [illegible]		DATE OF SIGNATURE [illegible]		DATE OF SIGNATURE [illegible]		DATE OF SIGNATURE [illegible]	

BUREAU V. 1

MAR - 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 212											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>			c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson R-2</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>Elmer School + Clark Hollow Rd</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ethan</u> Last <u>Poole</u>					4. DATE OF DEATH Month <u>Mar</u> Day <u>27</u> Year <u>1957</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-15-97</u>		9. AGE (In years last birthday) <u>60</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer - Orches - Retired</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>			11. BIRTHPLACE (State or foreign country) <u>md</u>			
13. FATHER'S NAME <u>Elgin Poole</u>					14. MOTHER'S MAIDEN NAME <u>Annie Elgin Poole</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>					16. SOCIAL SECURITY NO. <u>217-36-9076</u>						
17. INFORMANT <u>Raymond Poole (son)</u>					Address <u>Pooksville md</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>3/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Nelson</u>					ADDRESS <u>Barnesville Md</u>		24a. REC'D BY REGISTRAR <u>Mar 27 1957</u>				
							24b. REGISTRAR'S SIGNATURE <u>Charles E. Egan</u>				

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. E.

APR 1 1957

RECEIVED

03154

# CERTIFICATE OF DEATH

03143

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>North Carolina</b>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlotte</b> <b>70x-3</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Route #1, Box 25</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ted</b>		First <b>Edward</b>		Middle <b>Poole, Jr.</b>		Last <b>March 25,</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <b>March 25,</b>			
8. DATE OF BIRTH <b>October 20, 1956</b>		9. AGE (In years last birthday) yrs. <b>5</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b></b> Min. <b></b>		Year <b>19 57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ted Edward Poole, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Dillard</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Duodenal hemorrhage</b> DUE TO (c) <b>acute lymphocytic leukemia</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 7</b> , 19 <b>57</b> , to <b>March 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 25</b> , 19 <b>57</b> , and that death occurred at <b>3:10 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/25/57</b> ACTUAL SIGNATURE <b>Gurston Goldin</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Bethesda 14, Maryland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. - Transit</b>		22b. DATE THEREOF <b>3/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Gaston Co., N. Carolina</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3-28-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

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BUREAU V. S.

APR 1 1957

RECEIVED

Gaston

Greenwood

3/20/57

Robert A. Humphrey-Belinda, Ltd.



03155

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b <b>Kensington-Rock Creek Hills x2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9812 E. Bexhill Drive</b>				d. STREET ADDRESS <b>9812 E. Bexhill Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Fenner</b> Middle <b>D.</b> Last <b>POWELL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1890</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Kenton, Tennessee</b>	
13. FATHER'S NAME <b>Granville Parnell</b>				14. MOTHER'S MAIDEN NAME <b>Alice McKelvey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>W. W. I</b>		16. SOCIAL SECURITY NO. <b>579-07-9210</b>		17. INFORMANT <b>Lucy Powell-Same Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced coronary sclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>6 mos. +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from _____, 1950, to <b>March 2, 1957</b> , that I last saw the deceased alive on <b>March 2, 1957</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stewart Clapp</b>				M.D. <b>3921 Ingomar St. N. W. Wash. D. C. 3/2/57</b>			
PHYSICIAN'S NAME (Type) <b>Stewart Clapp, M. D.</b>				ADDRESS (Street, city or town, state) <b>3921 Ingomar Street, Wash. D. C. 3/2/1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/6/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</b>				24a. REC'D BY REGISTRAR <b>3-2-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G212 3-18-57 et

03145

03156

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6309 Tone Drive</b>		d. STREET ADDRESS <b>6309 Tone Dr., Beth., Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Margaret</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/83</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Josef Robitsek</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Benjamin A. Theeman, 6309 Tone Dr., Beth., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> <b>199.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic adenocarcinoma, primary</b> DUE TO (c) <b>site unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 7, 1957</b> to <b>March 11, 1957</b> , that I last saw the deceased alive on <b>March 11, 1957</b> , and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>901 20th St NW, Wash., D.C.</b> DATE SIGNED <b>3-11-57</b>			
ACTUAL SIGNATURE <b>Eugene S. Gladson</b> M.D. <b>901 20th St NW</b>			
PHYSICIAN'S NAME (Type) <b>EUGENE S. GLADSON</b> <b>Wash., D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Beth Olom Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Queens, L. I., New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons, 3501 14th St., N. W.</b>		24a. REC'D BY REGISTRAR DATE <b>3-13-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

BUREAU V. 8

MAR 15 1957

RECEIVED

## 03044 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>11 Nicholson St. NW.</u> b. COUNTY <u>Dist. Col.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakeview Hk.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San &amp; Hosp.</u>				d. STREET ADDRESS <u>11 Nicholson St. NW.</u>			
3. NAME OF DECEASED (Type or print) <u>Moses</u> First <u>Ratner</u> Middle <u>Ratner</u> Last				4. DATE OF DEATH <u>Mar 21</u> Month <u>1957</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Benjamin Ratner</u>				14. MOTHER'S MAIDEN NAME <u>Severa</u> ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Not</u>				16. SOCIAL SECURITY NO. <u>577-24-4056</u>		17. INFORMANT <u>Wash. San &amp; Hosp. Records.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>myocardial failure - acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Long duration</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/21</u> 19 <u>57</u> , to <u>March 21, 1957</u> , that I last saw the deceased alive on <u>3/21</u> 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Isaacson</u> M.D.				ADDRESS (Street, city or town, state) <u>2233 Alaska Ave. NW. Wash. D.C.</u>			
DATE SIGNED <u>March 12, 1957</u>							
PHYSICIAN'S NAME (Type)							
22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3/22-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Colessetgrad Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deering Funeral Home</u> ADDRESS <u>4217-9th NW</u>				24a. REC'D BY REGISTRAR <u>J. Nelson Podes</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>3/23/57</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		SUICIDE		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	
DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT	
MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	
DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT		DECEASED WAS FOUND AT	
MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	

BUREAU V. S.

MAR 26 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 5/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03157

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03147

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL) <b>Cabin John</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x 2 Cabin John</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7707 MacArthur Blvd.</b>				d. STREET ADDRESS <b>7707 MacArthur Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PERCY</b> Middle <b>EUGENE</b> Last <b>REDDEN</b>				4. DATE OF DEATH <b>Feb March 4, 19 57</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1890</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Cropley, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Ch. Quarterman U. S. Govt.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>			
13. FATHER'S NAME <b>William Thomas Redden</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Pennifield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Isabelle L. Redden-Same Item #2</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/7/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 7-5-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	
22d. LOCATION (City, town, or county) <b>Montgomery</b>				22e. (State) <b>Maryland</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased Robert J. Prochaska		Age 37	
Sex Male		Race White	
Date of Death March 4, 1957		Place of Death Home	
Cause of Death Coronary Occlusion		Manner of Death Natural	
Signature of Medical Examiner Isabelle I. Hedden		Signature of Coroner Isabelle I. Hedden	
Address of Deceased 7707 MacArthur Blvd.		City Crown Point	
County Montgomery		State Maryland	

**RECEIVED**  
 MAR 7 1957  
 BUREAU V. S.

Robert J. Prochaska  
 3/7/1957  
 Baltimore, Maryland

## CERTIFICATE OF DEATH

03148  
Reg. Dist. No. 216

03158

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Md.</b>				c. LENGTH OF STAY IN 1b <b>51 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Mae</b> Last <b>Reeder</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21, 1902</b>	
9. AGE (In years lost birthday) <b>54</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Legislative Researcher</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Reeder</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Lingo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>262-54-9922</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cirrhosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 23</b> , 19 <b>57</b> , to <b>March 15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 15</b> , 19 <b>57</b> , and that death occurred at <b>8.50 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>J. Wolff</b>				M.D. <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Jan Wolff, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3-18-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler's Sons</b>				ADDRESS <b>1756 Pa Ave. N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-18-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blaise M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 21 1957

BUREAU V.

RECEIVED



03159

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cherry Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>FREDRICK</b> Last <b>REMLER</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1898 April 15</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TILE</b>		11. BIRTHPLACE (State or foreign country) <b>PENN.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>HENRY REMLER</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Schaubhut</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>ROTC</b> (If yes, give war or dates of service) <b>1930</b>				16. SOCIAL SECURITY NO. <b>Ethel REMLER - ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL EMBOLUS</b> 420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AURICULAR FIBRILLATION</b> DUE TO							
(c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CIRRHOSIS OF LIVER</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>January</b> , 19 <b>57</b> , to <b>March 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 14</b> , 19 <b>57</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Morton C Creditor</b>				M.D. <b>WASHINGTON CLINIC</b> <b>3/14/57</b>			
PHYSICIAN'S NAME (Type) <b>MORTON C CREDITOR</b>				<b>WASHINGTON 15 D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>3/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grandview</b>		22d. LOCATION (City, town, or county) (State) <b>Beaver Falls, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 3-16-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03160

CERTIFICATE OF DEATH

Reg. Dist. No. 217

03150

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u> X1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>Box 195 Olney md</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Howard</u> Last <u>Riegner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk - rate Dept. Southern RR</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Howard Riegner</u>				14. MOTHER'S MAIDEN NAME <u>Louise Michaels</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. W. H. Riegner 1220 Dale Dr. Sil Sp</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arterio-Sclerosis</u> DUE TO (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/1/56</u> , 19 <u>56</u> , to <u>3/10/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/10/57</u> , 19 <u>57</u> , and that death occurred at <u>9:25</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3/10/57</u>			
PHYSICIAN'S NAME (Type) <u>J. W. BIRD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NORLAND CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CHAMBERSBURG, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner B. Pumphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>3-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Gertude B Lawler</u>	

CERTIFICATE OF DEATH

COUNTY OF DEATH BALTIMORE		NAME OF DECEASED [Illegible]	
SEX OF DECEASED [Illegible]		AGE OF DECEASED [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]	
MARITAL STATUS [Illegible]		RELIGION [Illegible]	
BIRTH DATE [Illegible]		BIRTH PLACE [Illegible]	
PARENTS' NAMES [Illegible]		SPOUSE'S NAME [Illegible]	
CHILDREN'S NAMES [Illegible]		GRAVE LOCATION [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	

BUREAU V. 3

MAR 21 1957

RECEIVED

TO BE FILLED IN BY THE CORONER OR HIS DEPUTY. TO BE RETURNED TO THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1200 Woodside Pkwy Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Cedar Haven Rest Home</u>				d. STREET ADDRESS <u>1200 Woodside Pkwy</u>			
3. NAME OF DECEASED (Type or print) <u>Margaret Jane Riffin</u>				4. DATE OF DEATH <u>March 25</u> 19 <u>57</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/11/1866</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dwight Evans</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mary Sears Evans</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of neck - 10 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>Feb 2</u> , 19 <u>57</u> to <u>March 25</u> , 19 <u>57</u> that I last saw the deceased alive on <u>March 25</u> , 19 <u>57</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u>			
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>				DATE SIGNED <u>Takoma Park 12 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIGGIN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner &amp; Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>3/27/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>William R. Ridd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1912</i></p>	
<p>5. PLACE OF BIRTH <i>Washington, D.C.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>March 25, 1957</i></p>	
<p>9. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>10. PLACE OF DEATH <i>Home</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	

BUREAU V. S.

MAR 28 1957

RECEIVED

03161

## CERTIFICATE OF DEATH

Reg. Dist. No. *d/6*

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> <i>xo</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>4504 Franklin St.</i>			
3. NAME OF DECEASED (Type or print) <i>Gertrude</i> First <i>L.</i> Middle <i>Rollins</i> Last				4. DATE OF DEATH <i>March</i> Month <i>15</i> Day <i>1957</i> Year			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 2-1884</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Eagleson</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Glick</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>William L. Rollins</i>		Address <i>2522 Glenwood Park New Albany, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Cerebral Vascular Hemorrhage</i> DUE TO <i>Maligant Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>2 days</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X diabetes mellitus</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>3/31</i> , 19 <i>57</i> , to <i>3/15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3/15/57</i> , 19 <i>57</i> , and that death occurred at <i>4:50</i> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>I. L. Marks</i>				ADDRESS (Street, city or town, state) <i>6306 Wisconsin Ave</i> DATE SIGNED <i>3/15/57</i>			
PHYSICIAN'S NAME (Type) <i>I. L. Marks</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/18/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Maryland</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>3-18-57</i> 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED  
MAR 19 1957  
BUREAU V. S.

Robert A. Pannone-Bernardo, Maryland  
3/18/57  
Mr. Oliver  
J. L. Marks

CHIEF OF POLICE  
3700  
1957

03162

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4418 Montgomery Ave.</b>				d. STREET ADDRESS <b>4418 Montgomery Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>P</b> Last <b>ROSENGARTH</b>				4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/7/1900</b>	9. AGE (In years last birthday) yrs. <b>56</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscape Architect</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Wm. A. Rosengarth</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NOT</b>			
17. INFORMANT <b>Wife</b>				Address <b>Above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 1956</b> , to <b>March 27, 1957</b> , that I last saw the deceased alive on <b>March 25, 1957</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Robert R. Montgomery M.D.</b>				<b>1746 K ST. N.W. 3/27/57</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT R. MONTGOMERY</b>				<b>WASHINGTON, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>3/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louis Wills Burial Gr.</b>		22d. LOCATION (City, town, or county) (State) <b>Gretna Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, 7557 Wisc. Ave. Beth.</b>				24a. REC'D BY REGISTRAR <b>DATE 8-28-57</b>		24b. REGISTRAR'S SIGNATURE <b>Benni M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
13. Name of informant		14. Relationship to deceased		15. Address of informant		16. Date of registration		17. Place of registration		18. Signature of registrar		19. Date of registration		20. Place of registration		21. Signature of registrar		22. Date of registration		23. Place of registration		24. Signature of registrar	

BUREAU V. 1

APR 1 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9, 7 Film 0214 4-22-57 et

03163

# CERTIFICATE OF DEATH

03154

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits) write RURAL and give nearest town <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 17</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>8107 GARLAND AVENUE</u>			
3. NAME OF DECEASED (Type or print) <u>PAULINE</u> First <u>Rothman</u> Middle Last				4. DATE OF DEATH <u>3 - 21 - 19 57</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 12 1878</u>	
9. AGE (In years last birthday) <u>78 7/9</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MUSIC</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA -</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>LAZAR SELTZER</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (Son) <u>MR BERNARD Rothman</u> Address <u>8107-Garland Ave. Takoma Park, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure (Congestive H. Failure)</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralytic Ileus - Cerebral Arteriosclerosis - Old Leptomenigitis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-25-57</u> to <u>3-21-57</u> that I last saw the deceased alive on <u>3-20-57</u> and that death occurred at <u>12</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Geo. A. Gray, Jr.</u> M.D. <u>104 Cherry Chase Dr.</u>				DATE SIGNED <u>3-26-57</u>			
PHYSICIAN'S NAME (Type) <u>Geo. A. Gray, Jr. M.D. Cherry Chase 15, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden, Falls Church, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Nanyansky &amp; Sons - 3501 14th St. N.W.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Bennie M. Thompson</u> DATE <u>3-26-57</u>		24b. REGISTRAR'S SIGNATURE	

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1957

DATE OF DEATH

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BUREAU V. R.

MAR 29 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03045

## CERTIFICATE OF DEATH

03155

Reg. Dist. No. 923

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>29 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7408 BALTIMORE AVENUE</u>				d. STREET ADDRESS <u>7408 Bolto Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Margaret ANN</u> First Middle Last				4. DATE OF DEATH <u>March</u> Month Day Year <u>3</u> 19 <u>57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/25/88</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Schneider</u>				14. MOTHER'S MAIDEN NAME <u>Fredricka Schulta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Joseph J. Rowan, 7408 Baltimore Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>cerebral arteriosclerosis</u> (c) <u>generalized arteriosclerosis</u> lying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 hrs.</u> <u>10 yrs</u> <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> 19 <u>47</u> , to <u>March 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>57</u> , and that death occurred at <u>9:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>		M.D. <u>785-2 16 &amp; 4 u</u>		ADDRESS (Street, city or town, state) <u>Wash DC</u>		DATE SIGNED <u>3/3/57</u>	
PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>3/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>William D. Bell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

MAR 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

21 08047 214 4-15-57 ans Item 16 Film G213 4-11-57 et										BALTIMORE, 18		03156	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.		773	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>								
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>					c. LENGTH OF STAY IN 1b <u>48 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>					d. STREET ADDRESS <u>4614 Aspen Hill Court</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kathryn</u> First <u>Isobel</u> Middle <u>Rupp</u> Last					4. DATE OF DEATH Month <u>3</u> - Day <u>31</u> - Year <u>1957</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-16-09</u>		9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Harry Baumgardner</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Sinn</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>217-10-0803</u>		17. INFORMANT <u>Hospital Records</u> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 917.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>2nd &amp; 3rd degree burns, Accidental</u> (c) <u>2nd &amp; 3rd degree burns, Accidental</u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>2nd &amp; 3rd degree burns from abdomen</u>								
20c. TIME OF INJURY Month, Day, Year Hour <u>4:30</u> <u>3-29</u> 1957					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Silver Spring Monty Md</u> (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Broschart</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>4-1-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>4-3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			22d. LOCATION (City, town, or county) <u>Frederick - Md.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Cline, Jr.</u>					ADDRESS <u>Frederick Md</u>		24a. REC'D BY REGISTRAR <u>3 April 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Duddy</u>				



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

APR 4 1957

RECEIVED

03161

## CERTIFICATE OF DEATH

03157

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4406 Woodfield Road</b>		d. STREET ADDRESS <b>4406 Woodfield Road</b>	
3. NAME OF DECEASED (Type or print) <b>FLORENCE</b> First Middle Last		4. DATE OF DEATH <b>March 12,</b> Month Day Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 26, 1912</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>16</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Holy Redeemer School</b>	
11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>David M. Roach</b>		14. MOTHER'S MAIDEN NAME <b>Florence Hughes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>George A. Schanzenbach-Item# 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon with metastasis</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory failure</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/12</b> , 19 <b>54</b> , to <b>3/12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/12</b> , 19 <b>57</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Florence R. Price</b> M.D. <b>4615 Edgefield Rd. Kensington</b> <b>3/12/57</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Florence R. Price</b> <b>4615 Edgefield Rd. Kensington Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>3/15/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 3-16-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Berni M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1957

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
JAMES H. WOODBURN		1912		Male		White		Married		Teacher		Heart Disease		Home		March 18, 1957		10:30 AM		J. H. Woodburn		J. H. Woodburn	
Place of Birth		Date of Death		Time of Death		Cause of Death		Place of Death		Date of Death		Time of Death		Cause of Death		Place of Death		Date of Death		Time of Death		Cause of Death	
Baltimore, Md.		March 18, 1957		10:30 AM		Heart Disease		Home		March 18, 1957		10:30 AM		Heart Disease		Home		March 18, 1957		10:30 AM		Heart Disease	
Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn		J. H. Woodburn	

BUREAU V. S.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03165

03158  
215

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Thomas</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park 18X22</b>			
d. STREET ADDRESS <b>384 Chinlee Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>John</b> Last <b>SCHNEIDER</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-30-57</b>		9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Le Roy E. Schneider</b>				14. MOTHER'S MAIDEN NAME <b>Jan L. Godfrey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>(Father) LeRoy E. Schneider (Same As #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary Atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. 11</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>30 March</b> , 19 <b>57</b> , to <b>30 March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>30 March</b> , 19 <b>57</b> , and that death occurred at <b>9:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>4-1-57</b>							
ACTUAL SIGNATURE <b>James C. Parke</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>James C. Parke, Jr. LT, MC, USN</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-3-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Purphrey, 7557 Wisconsin Ave., Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 4-1-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary C. Parrelly</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0304S

## CERTIFICATE OF DEATH

03159

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 hrs. 30 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Faye</u> Middle <u>Schwartz</u> Last <u>Schwartz</u>				4. DATE OF DEATH Month <u>3</u> - Day <u>16</u> - Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-17</u>		9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>16</u> Hours <u>19</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mass.</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Abraham Sudack</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Sobiloft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>014-09-4998</u>		17. INFORMANT Address <u>Washington Sanitarium &amp; Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>METASTATIC CARCINOMA</u> DUE TO <u>2 YRS.</u> lying cause last. (c) <u>PRIMARY CARCINOMA OF BREAST</u> <u>5-6 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>NOV 7</u> , 19 <u>55</u> , to <u>MARCH 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MARCH 16</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Sterling</u>				DATE SIGNED <u>1352 UNIVERSITY LANE</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>				ADDRESS (Street, city or town, state) <u>1440TSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Masonic</u>		22d. LOCATION (City, town or county) (State) <u>Hyattsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>4717-9th St</u>		24a. REC'D BY REGISTRAR DATE <u>3/18/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. W. R. R. R.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 19 1957

RECEIVED

03049

## CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First <b>Wilfred</b> Middle <b>Denham</b> Last <b>Seal</b>				4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-31-01</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>55</b> Days <b>16</b> Hours <b>19</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Assoc. Amer. R. R.</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
13. FATHER'S NAME <b>Alexander R. Seal</b>				14. MOTHER'S MAIDEN NAME <b>Annie Spick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I Army</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Peritonitis</b> <b>587.0</b> DUE TO (b) <b>Necrosis of Stomach</b> DUE TO (c) <b>Necrosis of left lobe of liver</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 days</b> <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(d) due to Chronic Pancreatitis (Hemorrhagic)</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>2-24</b> , 19 <b>57</b> , to <b>3-16</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-15-57</b> , 19 <b>57</b> , and that death occurred at <b>1:20 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur E Coyne</b>				ADDRESS (Street, city or town, state) <b>7600 Carroll Ave Takoma Park</b>			
PHYSICIAN'S NAME (Type) <b>ARTHUR E COYNE</b>				DATE SIGNED <b>3-16-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAR. 19. 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN</b>		22d. LOCATION (City, town, or county) (State) <b>BLADENBURG MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Tattoune</b>				ADDRESS <b>3619-14th ST NW</b>		24a. REC'D BY REGISTRAR <b>MAR 19 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. Nelson Saddy</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 19 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
5M 9/55

03165

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03161

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10117 Colesville Rd.</b>				d. STREET ADDRESS <b>No known address</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Danial Henry Shorter</b>				4. DATE OF DEATH Month Day Year <b>Mar 16, 1957 19</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>ool.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/1/ 1909</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>oady</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Dell Shorter</b>				14. MOTHER'S MAIDEN NAME <b>Rosy C. Curry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>357 Chapin St., S.E. Edith Marshall Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Found dead</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3/17/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John T. Rhines &amp; Co Fun. Home</b>		22d. LOCATION (City, town, or county) (State) <b>903 3rd St., Wash. D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 19 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>			



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Daniel Henry Shorley		47		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
April 19, 1957		Home		Heart Disease		Natural	
Residence		Occupation		Education		Religion	
No. 1234		Carpenter		High School		Catholic	
Marital Status		Previous Marriages		Present Address		Previous Address	
Married		None		1234 Main St., Baltimore, Md.		1234 Main St., Baltimore, Md.	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Director	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 19 1957

RECEIVED

John L. Hinton & Co. Inc.

Baltimore, Md.

03167

CERTIFICATE OF DEATH

03162

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Md.</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Box 120</b>			
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>George</b> Last <b>Siegrist</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> , Year <b>57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 4, 1930</b>		9. AGE (In years last birthday) <b>26</b> yes.	IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Siegrist</b>				14. MOTHER'S MAIDEN NAME <b>Maud Twitzhingzs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>264-52-6354</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic pneumonia</b> <b>2040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphatic leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bacteremia</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>February 7, 1957</b> , to <b>March 11, 1957</b> , that I last saw the deceased alive on <b>March 11, 1957</b> , and that death occurred at <b>2:55P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John Laszlo, M.D.</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>John Laszlo, M.D.</b>				DATE SIGNED <b>3/11/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit</b>		22b. DATE THEREOF <b>3/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Winter Park Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>9-14-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 18 1957

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03168

## CERTIFICATE OF DEATH

03163

Reg. Dist. No.

217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington D.C.</u> COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>5509-39th St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u>		First <u>Queen</u> Middle <u>Slye</u> Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Bess French Queen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ella J. Henrick</u> Address <u>Batchellors Forest Rd. Rockville - Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Senile Arteriosclerotic Degeneration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u>  <u>30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>27 Feb</u> , 19 <u>57</u> to <u>28 Feb</u> , 19 <u>57</u> that I last saw the deceased alive on <u>28 Feb</u> , 19 <u>57</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Boddy Ziegler, M.D.</u>				ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>1 March 1957</u>			
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 5 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertie B. Lawley</u>			

672E

BUREAU V.

MAR 5 1957

RECEIVED

1998

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03050

## CERTIFICATE OF DEATH

03164

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San. + Hosp.</u>		d. STREET ADDRESS <u>110003 Lorain Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harvey Jessie Smith</u>		4. DATE OF DEATH Month Day Year <u>3 - 9 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-75</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - mail service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mail service</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Ephraim Smith</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Rich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Clark</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Rt. Hemiplegia and aphasia</u> (b) <u>Generalized Arterio-sclerosis</u> DUE TO <u>Undetermined</u> (c) <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Prostatism - Urinary retention</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr 13, 1950</u> to <u>Mar 9, 1957</u> , that I last saw the deceased alive on <u>Mar 7, 1957</u> , and that death occurred at <u>1155 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u>		ADDRESS (Street, city or town, state) <u>7835 Eastern Ave Md. Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		DATE SIGNED <u>Mar 10, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>	22b. DATE THEREOF <u>3/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>DENVER, COLORADO</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR <u>3/12/57</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Burial, cremation, or removal.

VS. A15ME(5)  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03165
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										217
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>DOA.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hosp.</b>					d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>Smith</b> Last					4. DATE OF DEATH Month <b>Mar.</b> Day <b>16,</b> Year <b>1957</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 30, 1881</b>		9. AGE (In years last birthday) <b>75</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Richard Hall Silver Spring, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Mar 19, 1957</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pilgrim Baptist</b>			22d. LOCATION (City, town, or county) (State) <b>Linden, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>		

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BUREAU V. S.

MAR 26 1957

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03166  
214

03170

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>3½ months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>202 INDIAN SPRING DRIVE</b>				d. STREET ADDRESS <b>202 INDIAN SPRING DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NELLIE HELEN SMITH</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/30/74</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>BOSTON, MASS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PATRICK CARNEY</b>				14. MOTHER'S MAIDEN NAME <b>MARY KELLY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mr. C. Carney Smith, 202 Indian Spring Drive Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Diabetes mellitus</b> DUE TO (c) <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intertrochanteric fracture of left femur</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell over foot stool in home Jan 29, 1957</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>2 p. m. Jan 29 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Silver Spring, Mont., Md.</b>	
21. I certify that I attended the deceased from <b>Jan 29, 1957</b> , to <b>March 18, 1957</b> , that I last saw the deceased alive on <b>March 17, 1957</b> , and that death occurred at <b>3:55 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9210 Colesville Rd, Silver Spring, Md.</b> DATE SIGNED <b>3/18/57</b> ACTUAL SIGNATURE <b>Sydney Leventhal</b> M.D. <b>9210 Colesville Rd, Silver Spring, Md.</b> PHYSICIAN'S NAME (Type) <b>Sydney Leventhal, M.D.</b> <b>9210 Colesville Rd, S.S., Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>3/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MAPLE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HARTFORD, MICHIGAN</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>3/20/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances C. Geller</b>			



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES W. SMITH		2. SEX Male		3. AGE 45		4. DATE OF DEATH March 22, 1957	
5. PLACE OF DEATH Home		6. CITY Baltimore		7. COUNTY Baltimore		8. STATE Maryland	
9. OCCUPATION Teacher		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. W. Smith	
13. SIGNATURE OF DECEASED J. W. Smith		14. SIGNATURE OF WITNESSES J. W. Smith		15. SIGNATURE OF CLERK J. W. Smith		16. SIGNATURE OF REGISTRAR J. W. Smith	
17. SIGNATURE OF DECEASED J. W. Smith		18. SIGNATURE OF WITNESSES J. W. Smith		19. SIGNATURE OF CLERK J. W. Smith		20. SIGNATURE OF REGISTRAR J. W. Smith	
21. SIGNATURE OF DECEASED J. W. Smith		22. SIGNATURE OF WITNESSES J. W. Smith		23. SIGNATURE OF CLERK J. W. Smith		24. SIGNATURE OF REGISTRAR J. W. Smith	
25. SIGNATURE OF DECEASED J. W. Smith		26. SIGNATURE OF WITNESSES J. W. Smith		27. SIGNATURE OF CLERK J. W. Smith		28. SIGNATURE OF REGISTRAR J. W. Smith	
29. SIGNATURE OF DECEASED J. W. Smith		30. SIGNATURE OF WITNESSES J. W. Smith		31. SIGNATURE OF CLERK J. W. Smith		32. SIGNATURE OF REGISTRAR J. W. Smith	
33. SIGNATURE OF DECEASED J. W. Smith		34. SIGNATURE OF WITNESSES J. W. Smith		35. SIGNATURE OF CLERK J. W. Smith		36. SIGNATURE OF REGISTRAR J. W. Smith	
37. SIGNATURE OF DECEASED J. W. Smith		38. SIGNATURE OF WITNESSES J. W. Smith		39. SIGNATURE OF CLERK J. W. Smith		40. SIGNATURE OF REGISTRAR J. W. Smith	
41. SIGNATURE OF DECEASED J. W. Smith		42. SIGNATURE OF WITNESSES J. W. Smith		43. SIGNATURE OF CLERK J. W. Smith		44. SIGNATURE OF REGISTRAR J. W. Smith	
45. SIGNATURE OF DECEASED J. W. Smith		46. SIGNATURE OF WITNESSES J. W. Smith		47. SIGNATURE OF CLERK J. W. Smith		48. SIGNATURE OF REGISTRAR J. W. Smith	
49. SIGNATURE OF DECEASED J. W. Smith		50. SIGNATURE OF WITNESSES J. W. Smith		51. SIGNATURE OF CLERK J. W. Smith		52. SIGNATURE OF REGISTRAR J. W. Smith	
53. SIGNATURE OF DECEASED J. W. Smith		54. SIGNATURE OF WITNESSES J. W. Smith		55. SIGNATURE OF CLERK J. W. Smith		56. SIGNATURE OF REGISTRAR J. W. Smith	
57. SIGNATURE OF DECEASED J. W. Smith		58. SIGNATURE OF WITNESSES J. W. Smith		59. SIGNATURE OF CLERK J. W. Smith		60. SIGNATURE OF REGISTRAR J. W. Smith	
61. SIGNATURE OF DECEASED J. W. Smith		62. SIGNATURE OF WITNESSES J. W. Smith		63. SIGNATURE OF CLERK J. W. Smith		64. SIGNATURE OF REGISTRAR J. W. Smith	
65. SIGNATURE OF DECEASED J. W. Smith		66. SIGNATURE OF WITNESSES J. W. Smith		67. SIGNATURE OF CLERK J. W. Smith		68. SIGNATURE OF REGISTRAR J. W. Smith	
69. SIGNATURE OF DECEASED J. W. Smith		70. SIGNATURE OF WITNESSES J. W. Smith		71. SIGNATURE OF CLERK J. W. Smith		72. SIGNATURE OF REGISTRAR J. W. Smith	
73. SIGNATURE OF DECEASED J. W. Smith		74. SIGNATURE OF WITNESSES J. W. Smith		75. SIGNATURE OF CLERK J. W. Smith		76. SIGNATURE OF REGISTRAR J. W. Smith	
77. SIGNATURE OF DECEASED J. W. Smith		78. SIGNATURE OF WITNESSES J. W. Smith		79. SIGNATURE OF CLERK J. W. Smith		80. SIGNATURE OF REGISTRAR J. W. Smith	
81. SIGNATURE OF DECEASED J. W. Smith		82. SIGNATURE OF WITNESSES J. W. Smith		83. SIGNATURE OF CLERK J. W. Smith		84. SIGNATURE OF REGISTRAR J. W. Smith	
85. SIGNATURE OF DECEASED J. W. Smith		86. SIGNATURE OF WITNESSES J. W. Smith		87. SIGNATURE OF CLERK J. W. Smith		88. SIGNATURE OF REGISTRAR J. W. Smith	
89. SIGNATURE OF DECEASED J. W. Smith		90. SIGNATURE OF WITNESSES J. W. Smith		91. SIGNATURE OF CLERK J. W. Smith		92. SIGNATURE OF REGISTRAR J. W. Smith	
93. SIGNATURE OF DECEASED J. W. Smith		94. SIGNATURE OF WITNESSES J. W. Smith		95. SIGNATURE OF CLERK J. W. Smith		96. SIGNATURE OF REGISTRAR J. W. Smith	
97. SIGNATURE OF DECEASED J. W. Smith		98. SIGNATURE OF WITNESSES J. W. Smith		99. SIGNATURE OF CLERK J. W. Smith		100. SIGNATURE OF REGISTRAR J. W. Smith	

RECEIVED  
MAR 22 1957  
BUREAU V. S.

Item 18 Film 212 3-22-57 ams

03171

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If in hospital, give street and town) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>			
d. STREET ADDRESS <b>248 Hamilton St., N.W.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Bryan</b> Last <b>Spink</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 February 1952</b>	
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minor Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Edward W. Spink</b>				14. MOTHER'S MAIDEN NAME <b>Bernadette Couture</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory &amp; Cardiac failure</b> <b>192X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Retinoblastoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>29 December, 1956</b> , to <b>17 March, 1957</b> , that I last saw the deceased alive on <b>17 March, 1957</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 3-17-57</b> <b>National Institutes of Health</b> <b>Bethesda 14, Md.</b>							
ACTUAL SIGNATURE <b>Glenn A. Drager</b>				M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Glenn A. Drager</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/20/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				ADDRESS <b>2901 14th St., N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>MAR 20 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Leslie Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

MAR 20 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03172

## CERTIFICATE OF DEATH

03168

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>9 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lehwy house</u> d. STREET ADDRESS <u>3517 - Lammings Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Marie</u> Middle <u>M</u> Last <u>Stahl</u> <b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>18</u> Year <u>1957</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug. 29 1888</u> <b>9. AGE</b> (In years last birthday) <u>68</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>6</u> Days <u>19</u> <b>IF UNDER 24 HRS.</b> Hours <u> </u> Min. <u> </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>12. FATHER'S NAME</b> <u>Frederick Stahl</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Ruffert</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u> <b>17. INFORMANT</b> <u>Kathryn Deme</u> Address <u>13517 - Lammings Lane Bethesda, Md.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis intraabdominal</u> <u>175X</u> DUE TO (b) <u>Adeno Carcinoma Ovary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcific aortic valve Disease</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>3-11-57</u> <b>19</b> , to <u>3-18-57</u> <b>19</b> , that I last saw the deceased alive on <u>3-17-57</u> <b>19</b> , and that death occurred at <u>12:15 A.M.</u> , from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <u>Suite 400 8218 Wisconsin Ave</u> <b>DATE SIGNED</b> <u>3/18/57</u> <b>ACTUAL SIGNATURE</b> <u>Edward S. Witowski Jr.</u> <b>M.D.</b> <b>PHYSICIAN'S NAME (Type)</b> <u>EDWARD S. WITOWSKI JR.</u> <u>BETHESDA 14, MARYLAND</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/21/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Rockville</u> (State) <u>Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u> <b>ADDRESS</b> <u>Bethesda, Maryland</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>DATE 3-21-57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Bessie M. Thompson</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAITLAND STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

Blank certificate form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death.

BUREAU V. T.

MAR 26 1957

RECEIVED



03173

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>36 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>9113 Sudbury Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Alice</b> Last <b>Stover</b>				4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 20, 1908</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Company</b>			
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Paul Niles</b>				14. MOTHER'S MAIDEN NAME <b>Catherine McGovern</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>349-14-9912</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma involving cervical</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>mediastinal abdominal lymph nodes +</b> DUE TO <b>liver</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>February 13, 1957</b> to <b>March 21, 1957</b> , that I last saw the deceased alive on <b>March 21, 1957</b> , and that death occurred at <b>2:44 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/21/57</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland ACTUAL SIGNATURE <b>William J. Pieper</b> M.D. PHYSICIAN'S NAME (Type) <b>William J. Pieper, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wanda E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>3-25-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 26 1957  
BUREAU V. S.

03051

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN lb <b>5½ days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. &amp; HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>THERESA</b> Last <b>SULLIVAN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/83</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Lane</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Dailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Charles B. Murto, 1223 Noyes Drive</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>2+4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 47</b> , 19 <b>57</b> , to <b>Mar 13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 13</b> , 19 <b>57</b> , and that death occurred at <b>3:20 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. H. RICHWINE</b>		ADDRESS (Street, city or town, state) <b>5522 Western Ave, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. H. RICHWINE</b>		DATE SIGNED <b>5-7-57</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/15/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner C. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>3/14/57</b>		24b. REGISTRAR'S SIGNATURE <b>John A. Doherty</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 15 1957

BUREAU V. I.

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13	
CERTIFICATE OF DEATH	
00021	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. TIME OF DEATH	
10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR	
12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED	
14. SIGNATURE OF NEXT OF KIN	
15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF CEMETERY	
18. SIGNATURE OF CHURCH	
19. SIGNATURE OF OTHER	
20. SIGNATURE OF OTHER	
21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER	
23. SIGNATURE OF OTHER	
24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER	
26. SIGNATURE OF OTHER	
27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER	
30. SIGNATURE OF OTHER	

03174

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indianhead 08x22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>26 "D" Riverview Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lynn</u> Middle <u>Denise</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 March 1957</u>		9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Billy Joe Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Jane Langley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Father, Billy J. Taylor, (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL PULMONARY ATELECTASIS</u> <u>761.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ANOXIA</u> DUE TO (c) <u>PLACENTAL DYSFUNCTION</u>							INTERVAL BETWEEN ONSET AND DEATH <u>43 Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10 March</u> , 19 <u>57</u> , to <u>12 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 March</u> , 19 <u>57</u> , and that death occurred at <u>1:25 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Daniel Shuptar</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>3-12-57</u> PHYSICIAN'S NAME (Type) <u>Daniel Shuptar, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Camp Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Camp Hill, Alabama</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u>				ADDRESS <u>55 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>3-12-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary E. Barry</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051212XV3



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		FIREARMS		DR. JAMES H. HAYES	
TIME OF DEATH		HOURS		MINUTES		TEMPERATURE		PULSE		RESPIRATION	
10:00 AM		4		15		98.6		60		16	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		TITLE		ADDRESS		CITY	
APRIL 10, 1968		MEMPHIS, TENNESSEE		JOHN EDGAR HOOVER		DIRECTOR		FEDERAL BUREAU OF INVESTIGATION		WASHINGTON, D.C.	

BUREAU A. B.

MAR 14 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03175

## CERTIFICATE OF DEATH

03172

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>3 mos. 29 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>950 25th St., N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Grundy</u> Middle <u>George</u> Last <u>THOMAS</u>		4. DATE OF DEATH		Month <u>March</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>14 Jan. 1911</u>		9. AGE (In years lost birthday) <u>46 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Kirby S. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Lula B. Stinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1-19-34 to 5-28-46</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Official Navy Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma stomach with extensive metastases</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastases</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 5.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 Nov.</u> , 19 <u>56</u> , to <u>4 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4 March</u> , 19 <u>57</u> , and that death occurred at <u>7:53A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. McClenathan</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James E. Mc Clenathan</u>				DATE SIGNED <u>3-4-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers, 3072 "M" St., N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE 3-4-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
J. H. HARRIS (Jr.)		Male		45		1910	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1111 North Howard St., Baltimore, Md.		Physician		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
March 10, 1957		Home		100-100000		100-100000	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS (Jr.)		J. H. HARRIS (Jr.)		J. H. HARRIS (Jr.)		J. H. HARRIS (Jr.)	
DATE		PLACE		CAUSE		MANNER	
March 10, 1957		Home		Heart Disease		Natural	

BUREAU V. S.

MAR 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03173

03176

## CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Portersville - Rural</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Portersville</u> x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>L</u>				d. STREET ADDRESS <u>Rural</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Vernon</u> Middle <u>Thompson</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colony</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March-15-1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u> Hours <u>4</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Quarrying</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quarry</u>		11. BIRTHPLACE (State or foreign country) <u>Martinsburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Pierce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Clara Hebron, Portersville, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - nephrotic</u> <u>442 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>—</u>		(County) <u>—</u>	(State) <u>—</u>
21. I certify that I attended the deceased from <u>March-28, 1957</u> , to <u>March-31, 1957</u> , that I last saw the deceased alive on <u>March-28, 1957</u> , and that death occurred at <u>11:30 A-M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7-Brooks Ave., Martinsburg, Md</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>W. C. Miller</u>		M.D. <u>—</u>					
PHYSICIAN'S NAME (Type) <u>W. C. MILLER</u>		<u>Martinsburg, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Martinsburg,</u>		22d. LOCATION (City, town, or county) <u>Martinsburg, Md.</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swenson</u>			ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Elgin</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		SINGLE		WIDOW		DIVORCED		RE-MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY	
OCCUPATION		PROFESSION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		DEGREE		FIELD		YEAR	
RELIGION		CHURCH		SYNAGOGUE		TEMPLE		MOSQUE		OTHER		NAME		ADDRESS	
DATE OF DEATH		TIME		PLACE		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF NOTARY		SIGNATURE OF CORONER		SIGNATURE OF SHERIFF	
DATE OF SIGNATURE		TIME		PLACE		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	

BUREAU V. 2

APR 5 1967

RECEIVED



03177

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>2 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		d. STREET ADDRESS <b>Rt. #1, Goshen Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Otho Clark Trundle</b>		4. DATE OF DEATH Month Day Year <b>March 19 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/28/96</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Remus Trundle</b>		14. MOTHER'S MAIDEN NAME <b>Margaretta</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes War 1</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Mar. 18, 1957</b> , to <b>Mar. 19, 1957</b> , that I last saw the deceased alive on <b>Mar. 18, 1957</b> , and that death occurred at <b>12:35AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Jack Schumacher</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Jack Schumacher, M. D.</b> <b>Gaithersburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-22-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner</b>		24a. REC'D BY REGISTRAR DATE <b>3-21-57</b>	24b. REGISTRAR'S SIGNATURE <b>Bertrude B. Lawler</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH 1957		PLACE OF DEATH Home	
DECEASED Diney		MARRIAGE Married	
AGE 2 years		MOTHER Mrs. J. J. Diney	
FATHER Mr. J. J. Diney		BIRTH 1955	
OCCUPATION None		EDUCATION None	
RELIGION None		CITY Baltimore	
STATE Maryland		COUNTRY USA	
CAUSE OF DEATH Sudden Infant Death Syndrome			
MANNER OF DEATH Natural			
SIGNATURE OF PHYSICIAN [Signature]			
SIGNATURE OF REGISTRAR [Signature]			
DATE OF REGISTRATION 1957			
PLACE OF REGISTRATION Baltimore			
REGISTRATION NO. [Number]			

BUREAU V. 2

APR 1 1957

RECEIVED



03052

## CERTIFICATE OF DEATH

Reg. Dist. No.

273

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>75 Washington Sanitarium + Hosp.</i>		d. STREET ADDRESS <i>1919 Elhart St.</i>	
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>(IVMN)</i> Last <i>URCIOLO</i>		4. DATE OF DEATH Month <i>3</i> Day <i>13</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-29-80</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Italy</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Paul (unknown)</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Old Records (Washington Sam + Hosp.)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Uremia (Renal Insufficiency)</i> DUE TO (b) <i>Hypertension &amp; Cerebro Vascular</i> DUE TO (c) <i>Accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 hrs</i> <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 56</i> to <i>March 1957</i> , that I last saw the deceased alive on <i>March 13</i> , 19 <i>57</i> , and that death occurred at <i>12:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bernard A. Fitzgerald</i> M.D.		DATE SIGNED <i>3-13-57</i>	
PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>		<i>Silver Spring, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/16/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Seiers Funeral Home</i>		ADDRESS <i>WASH. DC</i> <i>- 3605-14th St. N.W.</i>	
24a. REC'D BY REGISTRAR <i>14</i>		24b. REGISTRAR'S SIGNATURE <i>J. Wilson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03176  
297

03178

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>unknown</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>none</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Anderson</b> Last <b>Walker</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1957</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 16, 1918</b>			
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>									
13. FATHER'S NAME <b>James Walker</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Sheppard</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>Hospital Records</b>					
17. INFORMANT <b>Hospital Records</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 592X DUE TO <b>Chronic Glomerulonephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Glomerulonephritis</b> DUE TO (c) <b>Chronic Glomerulonephritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b> <b>yes</b>								INTERVAL BETWEEN ONSET AND DEATH <b>no</b> <b>yes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <b>3/15, 1957</b> to <b>3/24, 1957</b> , that I last saw the deceased alive on <b>3/23, 1957</b> , and that death occurred at <b>6:58 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b> DATE SIGNED <b>March 24, 1957</b> ACTUAL SIGNATURE <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>[Signature]</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hopkins Chapel,</b>			
22d. LOCATION (City, town, or county) <b>Highland, Md.</b>				(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 29 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03177

03053

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>1105 W Franklin Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>(NMN)</u> Last <u>Warfield</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1881</u>	
9. AGE (In years last birthday) yrs. <u>75</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Procurement Division, Inspector U.S. Gov't</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government Worker</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John F. Warfield</u>				14. MOTHER'S MAIDEN NAME <u>Ella Stunkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Olive M. Warfield daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 months</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 1956, to <u>Mar 29</u> , 1957, that I last saw the deceased alive on <u>Mar 29</u> , 1957, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John T. Andrews</u>				ADDRESS (Street, city or town, state) <u>9601 Colleville Rd</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				DATE SIGNED <u>Mar 29-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>APR 1 - 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>William Dodel</u>			

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Grove</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Cedar Grove</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. Germantown</u>				e. STREET ADDRESS <u>1 R.F.D. Germantown</u>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>L.</u> Last <u>Watkins</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1885</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dairy Farmer Own Farm</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cedar Grove, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Noah Watkins</u>				14. MOTHER'S MAIDEN NAME <u>Julia Linthicum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Esther P. Watkins, Germantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis/Heart Disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 30, 1956</u> to <u>Mar 16, 1957</u> , that I last saw the deceased alive on <u>Mar 6, 1957</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack Schumacher, M.D.</u>				ADDRESS (Street, city or town, state) <u>26 N. Summit Ave., 3-18-57</u>			
PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M.D.</u>				DATE SIGNED <u>Baltimore, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chin L. Molsam</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Mar 18 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>			

CERTIFICATE OF DEATH

60713

217

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		65		JAN 15 1892		BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
LABORER		8		M		C		W		W		B		B	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
MAR 22 1957		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHIEF CLERK	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

MAR 22 1957

RECEIVED



Reg. Dist. No. 217

03180

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck</b>		c. LENGTH OF STAY IN 1b <b>2 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Philomena Rest Home</b>		d. STREET ADDRESS <b>41 Adams St. N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>C</b> Last <b>Webb</b>		4. DATE OF DEATH Month <b>March</b> Day <b>II</b> Year <b>1957</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept, 27 1866</b>	
9. AGE (In years and birthday) <b>90</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Agony Carman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Watch Life Insurance Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis I Webb</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Francis W. Webb</b>		Address <b>Silver Spring Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>15 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> 19 to <b>MAR 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 10</b> , 19 <b>57</b> , and that death occurred at <b>6 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>A.W. Smith</b> M.D. <b>4601 16th ST. NW</b> <b>A.W. SMITH</b> <b>Washington, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 14</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W Barber</b>		24a. REC'D BY REGISTRAR DATE <b>3-13-57</b>	
ADDRESS <b>Laytonsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur B. Lawrence</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MAY 1957		HOSPITAL		HEART DISEASE	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
MAY 1957		BALTIMORE		HIGH SCHOOL	
OCCUPATION		MARRIAGE		RELIGION	
RETIRED		MARRIED		CATHOLIC	
PREVIOUS ILLNESS		TREATMENT		POSTMORTEM	
HEART DISEASE		HOSPITAL		NO	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MAY 1957		HOSPITAL		HEART DISEASE	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
MAY 1957		BALTIMORE		HIGH SCHOOL	
OCCUPATION		MARRIAGE		RELIGION	
RETIRED		MARRIED		CATHOLIC	
PREVIOUS ILLNESS		TREATMENT		POSTMORTEM	
HEART DISEASE		HOSPITAL		NO	

BUREAU V. S.

MAR 21 1957

RECEIVED

03181

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLARKSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>1 Route I</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy WHITE</b>		4. DATE OF DEATH <b>MARCH 10th 1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 9, 1957</b>
9. AGE (In years last birthday) <b>14</b>		10. IF UNDER 1 YEAR <b>14</b> IF UNDER 24 HRS. <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CARL L. WHITE</b>		14. MOTHER'S MAIDEN NAME <b>MRS. HELEN J. McCONNELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>FATHER - Route #1 - Clarksburg, Md.</b>		Address <b>---</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Stenosis</b> DUE TO <b>762.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>---</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>---</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) (County) (State) <b>---</b>
21. I certify that I attended the deceased from <b>MARCH 9, 1957</b> to <b>MARCH 10, 1957</b> , that I last saw the deceased alive on <b>MARCH 10, 1957</b> , and that death occurred at <b>9:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. H. Bergstrom</b>		DATE SIGNED <b>MAR 10 '57</b>	
PHYSICIAN'S NAME (Type) <b>R. H. Bergstrom, M.D.</b>		ADDRESS (Street, city or town, state) <b>Rockville Med. Cent., Rockville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>3/14/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>3-14-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

BUREAU V. S.

MAR 18 1957

RECEIVED

03182

## CERTIFICATE OF DEATH

Reg. Dist. No.

03181

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>211 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>3830 N. 30th Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Foster</b> Last <b>White</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 15, 1915</b>	
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Idaho</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas White</b>				14. MOTHER'S MAIDEN NAME <b>Maude Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>215-32-8714</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant carcinoma, metastatic to liver</b> <b>152X</b> DUE TO <b>with resultant extensive hepatic parenchyma destruction</b> (b) <b>destruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Malignant carcinoma, primary in terminal</b> <b>sleep surgically resected 1955</b> DUE TO <b>sleep surgically resected 1955</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 6, 1956</b> to <b>March 5, 1957</b> , that I last saw the deceased alive on <b>March 5, 1957</b> and that death occurred at <b>9:00 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b> DATE SIGNED <b>3/5/57</b>							
ACTUAL SIGNATURE <b>Allan H. Levy</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Allan H. Levy, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>3-5-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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U. S. GOVERNMENT PRINTING OFFICE

MAR 7 1957

BUREAU V. R.

RECEIVED

03183

CERTIFICATE OF DEATH

03182

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				e. STREET ADDRESS <b>Manor Club Estates</b>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Barnsley</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/18/76</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas Barnsley</b>				14. MOTHER'S MAIDEN NAME <b>Mary Willard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intestinal Abstruction</b> <b>153X</b> DUE TO <b>Carcinoma Transverse Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/2/57</b> , 19 <b>57</b> , to <b>3/7/57</b> , that I last saw the deceased alive on <b>3/6/57</b> , 19 <b>57</b> , and that death occurred at <b>2:00A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. W. Bird</b>				ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>				DATE SIGNED <b>3/2/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Olney, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>3-10-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bertine B. Lawler</b>	

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03184

CERTIFICATE OF DEATH

031834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>(D. C.)</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13,301 Sherwood Forest Drive</b>				d. STREET ADDRESS <b>3611 Prospect Street, N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>STEELE</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 29, 1880</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel R. Steele</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. James W. John, 13,301 Sherwood Forest Dr. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thromboses (multiple)</b> 332x DUE TO <b>cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO <b>Heart block - complete</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Heart block - complete</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 27, 1955</b> to <b>March 14, 1957</b> , that I last saw the deceased alive on <b>March 13, 1957</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3000 Dent Place, N.W. Wash D.C.</b> DATE SIGNED <b>Mar 14 1957</b> ACTUAL SIGNATURE <b>R. Stephen Hulburt</b> M.D. PHYSICIAN'S NAME (Type) <b>R. Stephen Hulburt M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>March 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Kittanning, Penna.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>3/19/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Frances Collier</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>Charles Thompson</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>37</i></p>		<p>4. DATE OF BIRTH <i>May 15, 1929</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>		<p>7. CAUSE OF DEATH <i>Heart failure</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>	
<p>9. DATE OF DEATH <i>Mar 21, 1967</i></p>		<p>10. TIME OF DEATH <i>10:30 AM</i></p>		<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>14. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>15. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>16. SIGNATURE OF NEXT OF KIN <i>[Signature]</i></p>	

BUREAU V. S.

MAR 21 1967

RECEIVED

*Richard H. [Signature]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

03054

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03184  
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hosp</u>				d. STREET ADDRESS <u>3106 Dogwood St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>WILSON</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-20-99</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>no.</u>		11. BIRTHPLACE (State or foreign country) <u>MO.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U-S A</u>							
13. FATHER'S NAME <u>George Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Eva ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>4/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	
22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Heinen Co</u>				ADDRESS <u>2901-14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>APR 2 - 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>John A. Dell</u>							

BUREAU V.

APR 4 1957

RECEIVED

03185

CERTIFICATE OF DEATH

03185

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Roberta</b> Last <b>Wolf</b>				4. DATE OF DEATH Month <b>March</b> Day <b>21</b> , Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 18, 1911</b>	
9. AGE (In years lost birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>45</b> Days <b>18</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Teaching</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry Gordon</b>				14. MOTHER'S MAIDEN NAME <b>Esther Elkin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-36-8319</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, shock</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>lungatelectasis, diphtheria &amp; paralysis +</b> DUE TO <b>5 years -</b> (c) <b>metastatic carcinoma, widespread, of breast</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 17, 1957</b> , to <b>March 21, 1957</b> , that I last saw the deceased alive on <b>March 21, 1957</b> , and that death occurred at <b>9:45 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William J. Pieper</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
DATE SIGNED <b>3/21/57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons - 3501 14th St., N. W.</b>				24a. REC'D BY REGISTRAR <b>3-25-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 26 1957  
BUREAU V. S.

03055

## CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle <u>Carl</u> Last <u>Wyatt</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-74</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>		IF UNDER 24 HRS. Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired-Director of Personal Public Roads</u>			
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Josiah Nicholas Wyatt</u>				14. MOTHER'S MAIDEN NAME <u>Parina Parks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Chart</u>			
17. INFORMANT <u>Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 177X DUE TO <u>Compression of Thoracic spinal cord</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, metastatic from prostate</u> DUE TO (c) <u>Carcinoma, metastatic from prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>few hrs.</u> <u>few days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar 10</u> , 19 <u>57</u> , to <u>Mar 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 12</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul V. Starr</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Takoma Park, Md.</u>			
DATE SIGNED <u>3-13-57</u>							
PHYSICIAN'S NAME (Type) <u>Paul V. Starr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>City</u>		22d. LOCATION (City, town, or county) (State) <u>Newbern, Tenn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Hines Co., Washington DC</u>				ADDRESS <u>Chart</u>			
24a. REC'D BY REGISTRAR <u>15 1957</u>				24b. REGISTRAR'S SIGNATURE <u>J. H. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF NEXT OF KIN</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF NEXT OF KIN</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF NEXT OF KIN</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF NEXT OF KIN</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF NEXT OF KIN</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF NEXT OF KIN</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF NEXT OF KIN</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF NEXT OF KIN</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF NEXT OF KIN</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF NEXT OF KIN</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF NEXT OF KIN</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF NEXT OF KIN</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF NEXT OF KIN</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF NEXT OF KIN</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF NEXT OF KIN</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF NEXT OF KIN</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF NEXT OF KIN</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF NEXT OF KIN</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF NEXT OF KIN</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF NEXT OF KIN</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF NEXT OF KIN</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF NEXT OF KIN</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF NEXT OF KIN</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF NEXT OF KIN</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF NEXT OF KIN</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF NEXT OF KIN</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF NEXT OF KIN</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF NEXT OF KIN</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF NEXT OF KIN</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF NEXT OF KIN</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF NEXT OF KIN</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF NEXT OF KIN</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF NEXT OF KIN</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF NEXT OF KIN</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF NEXT OF KIN</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF NEXT OF KIN</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF NEXT OF KIN</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF NEXT OF KIN</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF NEXT OF KIN</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF NEXT OF KIN</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF NEXT OF KIN</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

MAR 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>27 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joyce</b> Middle <b>Ann</b> Last <b>Yokley</b>		4. DATE OF DEATH Month <b>3-</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/50</b>
9. AGE (In years last birthday) <b>6 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>26</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Derwood, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Yokley</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Rebecca Page</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>James Yokley (father) 9 Frederick Ave.,</b>	
17. INFORMANT <b>Rockville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Kidney Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive 3rd degree burns involving about 65% of body</b> DUE TO (c) <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>916.0</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Clothing caught afire while playin at trash fire</b>	
20c. TIME OF INJURY Month, Day, Year <b>2/27/57</b> Hour <b>4:30</b> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Rockville Montg Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-28-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b>		ADDRESS <b>Gaithersburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>3-28-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

APR 1 1957

BUREAU V. S.

840

03187

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <u>83X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>4348 N. Henderson Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>ZSELECZKY</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-57</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>30</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Emil Jacob ZSELECZKY</u>				14. MOTHER'S MAIDEN NAME <u>Rosalind J. Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Father) Emil J. Zseleczy (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal atelectasis</u> <u>757.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Congenital Hydronephrosis &amp; hydronephrosis</u> (c) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>75 min</u> <u>75 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 March</u> , 19 <u>57</u> , to <u>28 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>28 March</u> , 19 <u>57</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>3-29-57</u>							
ACTUAL SIGNATURE <u>John H. Mazur</u> M.D.				PHYSICIAN'S NAME (Type) <u>JOHN H. MAZUR, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u> ADDRESS <u>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 3-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

2051281XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1957

RECEIVED